Markets and Malthus

Population, Gender, and Health in Neo-liberal Times

Edited by
Mohan Rao
Sarah Sexton

IMF
World Bank
Multinationals
WTO

MARKETS
Muslim
Fundamentalists
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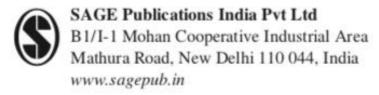
Christian
Fundamentalists
RELIGIOUS
LEADERS

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Mohan Rao would like to dedicate this book to his parents, Kapila and B.V.R. Rao, the most gentle, the rarest of parents; and to Imrana Qadeer, equally rare, teacher, and friend. They taught him that love and knowledge increases as it is shared, something neo-classical economists simply cannot understand.

Sarah Sexton would like to dedicate this book to her colleagues, Larry Lohmann and Nicholas Hildyard, without whom this book would not have been possible—but who sometimes are just two too menny . . .

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BNP	British Nationalist Party
CDC	Centers for Disease Control
CSIS	Center for Strategic and International Studies
CSMCH	Centre of Social Medicine and Community Health
CWPE	Committee on Women, Population, and Environment
DAWN	Development Alternatives with Women for a New Era
DISH	Delivery of Improved Services for Health
DPP	Decentralized Participatory Planning
ECSP	Environmental Change and Security Project
EPS	Environment, Population, and Security
ERSAP	Economic Reform and Structural Adjustment Program
FDA	Food and Drug Administration
G–7	Group of 7 (Seven of the world's leading countries that meet periodically to achieve a cooperative effort on international economic and monetary issues.)
GDP	Gross Domestic Product
HERA	Health Empowerment Right and Accountability
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INGO	International Non-governmental Organizations
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
IVF	In Vitro Fertilization
IWHC	International Women's Health Coalition
JCRC	Joint Clinical Research Center

LACWHN	Latin American and Caribbean Women's Health Network
MTP	Medical Termination of Pregnancy
NEP	New Economic Policies
NGO	Non-governmental Organizations
NPP	National Population Policy
NSC	National Security Council
OECD	Organization for Economic Co-operation and Development
PGSI	Pew Global Stewardship Initiative
PHN	Population, Health, and Nutrition Office
POA	Program of Action
PRB	Population Reference Bureau
PRI	Panchayati Raj Institutions
RCH	Reproductive and Child Health Program
RSS	Rashtriya Swayamsevak Sangh
SAP	Structural Adjustment Program
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFA	Target Free Approach
TFR	Total Fertility Rate
TRCHS	Tanzania Child Health Facility Survey
UDHS	Ugandan Demographic and Health Survey
UN	United Nations
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHP	Vishva Hindu Parishad
WAD	Women and Development
WEDO	Women's Environment and Development Organization
WHO	World Health Organization
WICEJ	Women's International Coalition for Economic Justice
WID	Women in Development
WGNRR	Women's Global Network for Reproductive Rights
WTO	World Trade Organization

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Introduction: Population, Health, and Gender in Neo-liberal Times

MOHAN RAO AND SARAH SEXTON

. . . VHP president Ashok Singhal said Hindus should give up family planning so that their population does not go down . . . He said population of minorities, especially Muslims, had been rising at "such a fast pace" that it would be 25 to 30 percent of the total population in 50 years. Singhal said it would be "suicidal" for Hindus if they did not raise their population. (Singhal 2004)

Unless we act to change our country's immigration policies, US population will double this century . . . Unfortunately, this flow of people into the US has not relieved population pressures in the countries of origin . . . [T]he populations of most developing countries . . . have continued to grow . . . Because our high resource consumption is exacerbated by our intake of immigrants, our population growth is compromising the environmental futures of not just our own country, but of the rest of the world—from many other countries from which we extract resources. (Elbel 2008)

Population growth is one of the factors contributing to global warming . . . Developing countries, especially those with rapid population growth, promise to worsen this problem [of man-made global warming pollution] as they too develop, using the model of wasteful, energy-intensive Western economies . . . Stabilizing population growth worldwide . . . are vital components of slowing, and eventually stopping, global warming.[1]

If we don't increase our sterilization targets, there will be 3 million more UPites. Can we cope with that? I get irritated when I see a woman with four children . . . I am on a self-propelled sterilization mission. (Anthony 2006)

Underpinning many an argument about population or over-population is the work of English economist and clergyman Thomas Robert Malthus, who is best remembered for the "law of nature" he first set out in his 1798 *An Essay on the Principle of Population* (Malthus 1798). His theory maintains that, as people have children, grandchildren, and so on, they will eventually go hungry because agricultural production just cannot keep up. Malthus claimed that food production increases at an arithmetic rate (1, 2, 3, 4, 5 . . .), but the number of people doubles every 25 years because it grows at a geometric rate (1, 2, 4, 8, 16 . . .), unless people delay and check their childbearing through late marriage and self-discipline (or through polygamy, infanticide, abortion, and contraception, all of which Rev. Malthus did not, of course, approve of). If they did not keep their numbers in check, warfare, epidemic disease, and starvation would do so—and because Malthus believed that poorer people found self-restraint or self-discipline difficult; disease and starvation were not only inevitable but also natural. His theory was, after all, a "law of nature".

Malthus continued writing and revising his theory over the next 30 years—and finally admitted that his mathematical and geometric series of increases in food and humans were not observable in any society. He ultimately acknowledged that his famous "power of number" was only an image, an admission that only some demographers have since confirmed. Most demographers around the world are, of course, trained in Malthusian certitudes.[2]

But despite it being a largely imaginary exercise in heuristics, various political and economic interests have invoked his theory and arguments ever since as a fact to bolster and support their interests. They have held the number of people—population—or the growth in population to be the ultimate cause of a plethora of local, national, regional, and global problems: deforestation, pollution, environmental degradation, poverty, hunger, urbanization, crime, war and conflict, social instability, slow economic growth, security, unemployment, and migration to name a few. Tackling these problems directly is considered futile unless external forces take action to control, slow, and stabilize the growth in population.

The dominance of this thinking among policymakers and bureaucracies worldwide can in large part be traced back to the 1950s when the United States became the dominant power researching and deploying neo-Malthusian arguments as a justification to contain communism in other

countries and to pursue various development policies (Ross 1998). It was at this time that many countries adopted what most people think of today as population policies. These tended to have a narrow agenda of reducing women's fertility so as to reduce the numbers of people in a country, or at least to reduce the rate at which numbers were increasing. In many places, particularly in Asia, such population control programs became synonymous with top-down, target-driven, often coercive, occasionally violent, sterilization and contraception programs. These programs often grew at the cost of general health services. Thus, a pregnant woman would not receive any care during her pregnancy or at childbirth until her third pregnancy, when she typically became a "case" for sterilization (Rao 2004). Funds for family planning programs grew exponentially in places where there were little or no health services available (Connelly 2008).[3]

Many women's health groups supported contraception that contributed to human health, welfare, and self-determination by enabling women and men to have greater influence over the timing and spacing of births, but opposed contraception that harmed women's health and welfare, especially when devised and provided without sufficient safety considerations. Feminist scholar Betsy Hartmann, for instance, pointed out that, "Married to population control, family planning has been divorced from the concern for women's health and well-being that inspired the first feminist crusaders for birth control" (Hartmann 1995: 37–38).[4]

In the early 1990s, some influential women's health groups, primarily based in the West but supported by some prominent "Southern" women, believed that working more closely with governments, international donor agencies or United Nations Population Fund (UNFPA) might ensure better reproductive health and counter their abuses. A combination of women's rights activists, feminist academics, and health activists from various countries decided to try to influence the UN's International Conference on Population and Development (ICPD), the third decennial population conference organized by UNFPA, which was to be held in Cairo, Egypt, in 1994. Their aim was to get governments to encompass women's reproductive rights and gender equity within their population policies. Many of them brought to the fore First World feminist concerns, in particular the right to abortion, which was increasingly threatened, since religious fundamentalists had come to dominate government policies in the United States in the 1980s and 1990s under the Reagan and

two Bush presidencies. Others had campaigned for many years against coercive population control programs and policies in the Third World. All were united in their opposition to the growing influence of fundamentalist groups in the USA, conservative Islamic countries and the Vatican (Petchesky and Judd 1998).

Joining these women were several groups from the population control establishment, comprising a wide array of actors ranging from the World Bank and Population Council to a number of International Nongovernmental Organizations (INGOs), nation-states, health personnel, and academics (Bandarage 1997). Although seemingly opposed to the feminist camp, this extremely influential group had apparently realized that the demographic goal of reducing women's fertility could not be attained without taking into account women's ability to make decisions regarding reproduction and fertility. Even for purely instrumental reasons, they realized they had to change their approach to the population issue.

Acting together, these groups crafted what has become known as the "Cairo consensus" (after the Egyptian capital that hosted the ICPD) of which the most tangible output was the ICPD's Programme of Action that was intended to govern population policies around the world for the following two decades and was signed by some 179 countries.

The Programme of Action drew unprecedented acclaim: it was described as a turning point in the history of the population field, and a sea change in the way population and reproductive health are conceptualized (Haberland and Measham 2002). More frequently, it has been described as a paradigm shift in the way population and development are understood. It has even been described as revolutionary (Cornwall and Welbourn 2002). Why? Because the Programme of Action put women's empowerment and reproductive health firmly at its center. It signaled a distinct break from demographically-driven population policies that "attribute poverty and environmental degradation to women's high fertility, and, in turn, women's high fertility to an absence of information and methods" (Petchesky and Judd 1998: 2). It challenged the "moral arsenal" of Christian, Hindu, or Islamic fundamentalisms to curtail rights of women in the name of tradition or culture, most often fraudulent and concocted. It redefined the population field that had neglected sexuality and gender roles, focusing instead largely on outcomes such as contraceptive efficacy or declines in birth rates, or, more recently, reproductive infections (Dixon-Mueller 1993). Above all, it provided a fillip and sanction from international covenant to

health and women's groups opposing coercive population programs (while struggling desperately for women's rights) in a number of countries. It was now possible for these groups to argue that these programs violated international covenants to which their governments were signatories. Even though demands for reproductive rights and health did not originate in Cairo, and were not formulated by the population control agencies or other international agencies that supported them (Ravindran 1998), it was in the "Cairo consensus" that they cast their influential shadow.

In the years since the 1994 ICPD, it has become rare to hear women's or health groups complaining about a country's heavy-handed population policy. Does this suggest that the Programme of Action agreed at Cairo solved the problems that had dogged population policies for decades? Do most women now have access to reproductive health? Are they able to exercise their reproductive and sexual rights? Are social and environmental ills now attributed to other causes instead of population growth and women's fertility?

Unfortunately, the answer is a resounding "no".

Although population growth rates and women's fertility rates are tumbling in country after country around the world (although it's impossible to say whether this is because of population policies or not), major social, environmental, and economic problems are still attributed at root to population growth and thus to women's fertility. Some of the most recent additions are climate change and terrorism.

Neo-Malthusianism continues to unite the elites of the world and to hold powerful sway in a range of areas. In India, where population growth rates are falling, most policy-planners continue to believe that "Cairo was wrong" and that some element of coercion is needed to bring down fertility rates. Mistakenly, China's enormous economic growth is attributed to the "success" of its family planning program, and it is argued that India has some hard lessons to learn. Many regard Cairo as simply a "will of the wisp" that UNFPA and perhaps the World Bank wanted all countries to sign, but no more. More powerfully and distressingly, population growth arguments are imbued in the growth of vicious anti-Muslim pogroms, as in Gujarat in 2002 (Rao 2007). In the United States, population arguments take the form of youth bulge theories, and are at the center of discourses on security issues and the rise of Islamic terrorism (Hendrixson 2004). In many countries in the West where immigration is a sensitive political issue, the problem is stated to be population growth in poor countries.

Ever since Malthus wrote his first *An Essay on the Principle of Population*, his theory and arguments have been refuted endlessly by empirical evidence indicating that any problem attributed to human numbers can just as easily have a different explanation, or that the statistical correlation is ambiguous. But facts and figures have never had much effect on population debates and disagreements over policies because, deep down, the disagreements are political and economic disagreements, always tinged with an element of the cultural, not scientific ones. They are less about numbers than about rights, economic markets, and welfare. Overpopulation arguments and the policies based on them tend to persist, not because of their intrinsic merit, but because of the ideological advantages they offer to powerful political, economic, and social interests.

Moreover, women's health and rights continue to be undermined in many ways during this period, despite the so-called Cairo consensus. Women in some countries are still coerced into being sterilized. During 1996, for instance, family planning providers intimidated and humiliated indigenous, poor, and rural women in the Peruvian Andes into being surgically sterilized after offers of food and clothing had not persuaded them. In Indonesia, poorer women do not have access to contraception, even though the country was held up at Cairo in 1994 as an exemplar of family planning provision. In India, several states have introduced a two-child norm for those who wish to contest local elections, while others have introduced such norms for access to government schools.

In many parts of the world, maternal mortality rates—a measure of the number of women dying each year from pregnancy-related causes—have stagnated or worsened, as have infant and child morbidity and mortality rates. Some 600,000 women die each year, 95 percent of them in sub-Saharan Africa and Asia, while 18 million are left disabled or chronically ill because of largely preventable complications during pregnancy or childbirth. These figures indicate that many women do not have access to essential and emergency obstetric care from skilled health workers, let alone access to more comprehensive reproductive health services. In 2000, between 115,000 and 170,000 women died in childbirth in India, accounting for about one-quarter of all maternal deaths worldwide (Freedman et al. 2004). Far from declining over the 1990s, maternal and neo-natal morbidity and mortality rates in India have at best plateaued, at worst increased (Ved and Dua 2005).

Indeed, many positive trends in the health of women the world over, from North to South, East to West, have been reversed over the past two decades, while reproductive health and rights remain threatened, particularly for poorer women, migrant women, and women of color. An estimated 330 million people are infected each year with sexually transmitted diseases, of which Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) accounts for six million; women and children are disproportionately affected. Some 70 percent of deaths at childhood can be attributed to diarrhea, pneumonia, measles, malaria, and malnutrition, the incidence of which is on the rise.

And anti-feminisms are increasing the world over, accompanied by increasing levels of violence against females ranging from sex-selective abortions to overt violence directed at women, especially poorer ones. A striking fact is that infant and child sex ratios in many parts of the world have turned anti-female, not just in the "Orient" (United Nations Secretariat 2003). There is also consensus that exploitation of women in the sex industry and of young children has increased as well over the past decade.

As for the Cairo agenda, various factors and forces have come together to make sure that the Programme of Action has not been implemented to any significant degree, something that several regional women's groups had documented even before the turn of the millennium (ARROW 1999; Development Alternatives with Women for a New Era 1999; Sadasivam 1999). The cause is usually stated to be a lack of resources, but the actual cause is a lack of political will: over the same period, governments found enormous resources to increase their military expenditure. Indeed, both India and Pakistan received opprobrium when they announced themselves to have become nuclear states, but Israel, another nuclear state, did not. There was clearly a new global context; in this it was becoming evident that the tryst made with promises that were Cairo was precisely that: empty promises.

Besides policy implementation, Cairo's policy rhetoric (along with any international policy or practice that touches on women's human rights) is now repeatedly challenged by the conservative forces that dominated politics in the USA (at least until 2009). Some commentators have declared that, far from being successful, Cairo is simply dead. In 2004, a decade after Cairo and mid-way through the Programme of Action's allotted time span, several women's groups concluded that it was best not to

attempt to revise or improve the Programme of Action (which they now acknowledged had several flaws) as the whole program might just get completely swept away.

Critically, however, the world has been changed fundamentally since the 1994 ICPD by the so-called neo-liberal consensus. Already at the time of Cairo, it was known that neo-liberal "reforms" during the 1980s had wreaked so much devastation in Africa and Latin America, the first continents to be "structurally adjusted", that United Nations Children's Fund (UNICEF) felt compelled to call for structural adjustment "with a human face". Even in 1994, the world was already being deeply changed by the neo-liberal hegemony—the political movement championing economic or free-market liberalism with minimal state intervention as a means of promoting economic development.

Since then, it has become clearer that international regimes of trade and finance increasingly threaten the livelihoods and the health of poorer people, even as health and wealth inequalities increase within and between countries.

The overpopulation argument completely elides the fact that there occurs a net transfer of close to 80 billion dollars annually from the countries of the South to those of the North. Indeed, this figure has increased substantially over the last three decades. In short, the poor countries are subsidizing the wealth of the rich countries, even as they are blamed for all global ills. That region of the world, considered the bread basket of the back of beyond, sub-Saharan Africa, annually transfers 13.4 billion dollars to its creditors in the West, which is substantially more than what it spends on education and health combined. From 1987 to 1993, the net transfer of resources from Africa to the International Monetary Fund (IMF) was 38 billion dollars (Gershman and Irwin 2000). During this period, when a number of countries have implemented structural adjustment programs, inequalities within and between countries have risen sharply: the income gap between the world's richest and poorest has more than doubled. In 1960, 20 percent of the world's people in the richest countries had 30 times the income of the poorest 20 percent; today they command 74 times more (Harvey 2005). The same richest 20 percent of the population command 86 percent of the world GDP while the poorest 20 percent command merely 1 percent. No amount of cutting—or reducing—birth rates among these populations will make any difference to global wealth, national wealth, or indeed to global problems of the environment.

Changes in the global economy over the last three decades have been accompanied by dramatic reversals of health gains made in the post-Second World War period. While some countries have witnessed stagnation in health indices, others have seen dramatic declines. At the same time, what is termed the health divide—between rich nations and poor nations, and between the rich and poor within countries—is increasing dramatically. For example, the gap in the under-five death rate, considered a sensitive indicator of social and economic development, has widened between the rich countries and the poor. The under-five death rate gap increased from a ratio of 7.8 in 1978 to 12.5 in 1998. Similarly, the death rate ratio in the age group five to fourteen has also increased from 3.8 in 1950 to seven in 1990.

It is generally accepted that these widening health inequalities are the consequence of the imposition of the World Bank and IMF-led policies of structural adjustment, and the accompanying health sector reforms, around the globe. In the past two decades, in much of the Third World, health services have collapsed; the so-called "health sector reforms" advocated by the World Bank—a powerful backer of the Cairo consensus—have led to further disparities in health access, even as they have increased the financial burden of ill-health and disease.[5] The World Bank, the IMF along with the World Trade Organization (WTO) (whose structure and remit was being finalized as the Cairo document was being signed), now have more influence and control over health policies than the World Health Organization (WHO). World Bank loans for one disease alone, malaria, exceed the entire budget of the WHO.

In addition to reducing states' commitments to health, typically, the Bank's health prescriptions are committed to methodological individualism and to behaviorism; they do not recognize the structural factors that govern and contour health or the ecology of disease. Further, they are also typically constrained by cost-benefit considerations that cannot always be legitimately applied to health situations. As a result, interventions tend to be disjointed (Oral Rehydration Salts to treat diarrhea rather than an emphasis on water supply and sanitation; a focus on anemia in pregnancy but not anemia in general; emphasis on medicine but never on food), and of a technical nature, what is referred to as the biomedical approach in public health. This has led to the strengthening of the discredited approach of disease-centric vertical programs.[6] Globally—and indeed reflecting

this, even in India's *National Health Policy 2002*—it is recognized that health sector development in the past has failed because of such vertical program development approaches. Assuming there is a grave fiscal crisis—which still seems to allow for the rich to be subsidized in a variety of areas—these prescriptions typically call for reducing spending on general health services, raising funds from the public, including charging fees for services, and instituting a variety of public–private partnerships, or simply privatizing services outright. At the same time, countries such as India have substantially funded the growth of the high-tech health sector in private or for-profit hands to promote health tourism. Again, the experience across the world has been that this trend excludes the poor from access to health services. Indeed, it is this explicit recognition that led countries like Zambia to do away with this policy prescription. What the package of prescriptions tends to do is to wrench apart comprehensive public health care, entrust profitable sectors of it to the private sector, and enjoin the state to subsidize a minimum clinical package, which typically involves family planning.

The global experience with this approach to health sector development has been dismal, not just in poorer countries. In Russia, following the neo-liberal changes in the economy and the accompanying health sector reforms, between 1991 and 1994, life expectancy among men decreased by close to seven years, from 63.6 to 57.5 years; among women the decline was close to three years, from 74.4 to 71.1 years (Shkolnikov et al. 2001). Such a decline in life expectations in populations not at war or suffering the onslaught of that other horse of the apocalypse, famine, is historically unprecedented. Accompanying the collapse of under-funded systems of health care, a booming private health system has emerged, along with a resurgence of old communicable diseases and hunger. The most telling data are from the United Kingdom revealing increasing mortality differentials by social class. The Black Report of 1980 indicated that mortality rates among unskilled working class men in 1971 were higher than they had been ever in the 20th century (Townsend and Davidson 1992). For instance, the Report noted that mortality levels among men aged 15–64 years in social groups 1 and 5 were 88 and 142 in 1911; in 1971, despite the National Health Service and the advances in medical technology of the period, they were 66 and 166. In the United States, too, despite overall decline in death rates, socio-economic disparities in mortality rates were increasing in the last decades of the 20th century (Marmot and McDowall

1986). Meanwhile, data also indicates that height differences among children have widened by social class in the UK in the years since the Black report, as indeed they have in China since 1979 when China initiated economic and health sector reforms (Liu et al. 2001).

These differences are despite the fact that these countries spend much more on health than India does, not only in absolute per capita terms but also as shares of national income or public budgets. The UK spends 6 percent of its national budget on health, India less than 1 percent. In contrast, the USA spends 12 percent of its budget on health. The UK relies on universal coverage and a state-supported National Health Service (albeit one that is being privatized by the back door), and has better health indices than the USA despite less spending on health. In the USA, about 40 million people have no health coverage, while Infant Mortality Rates (IMRs) and Under-Five Mortality Rates (U5MR) are significantly higher than in the UK (Pollock 2004). All this, then, calls for a fundamental re-think of some neo-liberal shibboleths such as the supposed inefficiency of the public sector and the greater efficiency of market-driven private behavior. Sri Lanka offers an excellent example of state-led quality health care provision. In Sri Lanka about 97 percent of in-patient care and 83 percent of out-patient care is in the public sector, where they have also integrated so-called indigenous systems of medicine. Sri Lanka has, of course, the best health indices in South Asia, rivaling those of First World countries, spending proportionately less than India does.

One of the startling aspects of what began as a thinning of the state but has now clearly become its emptying, hollowing, even gutting, has been the growth of Non-governmental Organization (NGOs), aided by policy in the West, among donors, multilateral institutions, and also among Third World countries. Indeed, it is prominent members from this sector, claiming to represent women in the South, who acclaimed the Cairo consensus despite deep misgivings in other sectors of the women's movement.

In 1995, for instance, the ICPD's Programme of Action came in for devastating criticism from seven all-India women's organizations:

> The slogan of sisterhood needs to be placed in the contemporary international situation when the so-called developed First World, led by the USA, wants to impose its agenda on the rest of the world in the name of globalisation . . . [T]he direct impact was seen in the recent Conference at Cairo . . . where the agendas of the G7 group were pushed through and issues concerning Third World women were left unaddressed.

> For instance, in Cairo the issue of abortion dominated the proceedings. The representatives of million of Third World women in Cairo hoped, while supporting the struggles of Western women for their right to abortion, at least some attention would be paid to their experience [of coercive population programmes]. Instead they did not get the support of women representing the First World. (*Lokayan Bulletin* 1995)

So deafening were the cries of victory at Cairo that such voices were not heard.

There was, of course, no Original Sin committed at Cairo when liberal feminists, predominantly from the West, went into alliance with the neo-Malthusian population control establishment. Indeed, it was precisely this relationship that had spawned the global population control movement in the 1950s, although in the troubled years since then, there had been a critical distancing. But the fact that some "reproductive health feminists" decided to be fellow travelers with the World Bank, along with the population control establishment, was entirely new (Hodgson and Watkins 1997)

It could be argued that in the agenda of rights that the ICPD espouses, reproductive choice refers to the plethora of contraceptive devices from which a "free" woman is supposed to be "empowered" to choose. In other words, that what is being created is a "rational", utility-maximizing consumer in the contraceptive marketplace, produced by the reproductive technology industry of the West. In an era of reproductive technologies, the concept of choice has been reduced to a consumption that fosters a private enterprise in women's bodies (Raymond 1996). Was this, then, what all the storm and thunder of reproductive rights was really about? Making contraceptives more acceptable, particularly the new generation of contraceptives, such as injectables and implants for which the World Bank's influential report *Investing in Health*, makes a case (World Bank 1993)?

It was largely the US liberal—and excessively White-feminist agenda that shaped the "consensus" at Cairo. Indeed as UNFPA head Nafis Sadik disarmingly noted: "it was American leadership above all which drove the Cairo process along" (cited in Hodgson and Watkins 1997: 49). Rechristening family planning programs as reproductive health programs, and renaming population control programs as gender equity programs, provided a politically correct rationale to discredited programs, thereby

giving them a new lease of life. It was indeed a case of new wine in old bottles.

It is above all in population policies—or in today's parlance repro-ductive health—that women are at the center of attention. It is here that a strange reordering of gender takes place, a divorce of women from their productive roles and a relegation to their reproductive ones alone. Through the population lens, women are not seen as citizens and fellow-creatures struggling with their everyday lives, to make ends meet, to look after children and increasingly the sick and elderly; they are regarded solely as bearers of children, as dangerous uncontrollable fertility, and as repositories of culture, community, tribe, or race. On the one hand, they are victims of population control policies, on the other they are victims of fundamentalist policies aimed at controlling women; both hands, however, have been suffused with neo-liberalism. If the state can't have welfare functions any more to further the development of capital, women should take on that role. If the state withdraws its function of protecting lives, then women are victims of "tradition", an assumption that obtains a new sanction in these neo-liberal times accompanied by the shrill and dangerous politics of identity.

At the beginning of 2009, it has become clear that the neo-liberal eco-nomic model has lost its shine as economy after economy around the world grinds to a halt. Talk abounds not only of recession, but also of depres-sion, the depth of which has not been seen since the 1930s, if not before. Does the economic crisis mean that the neo-liberal model of health care services will also collapse? Will population thinking fall into the doldrums as well? After all, Thomas Malthus was first and foremost an economist whose theories were designed to support capitalist development and to naturalize the poverty it caused (rather than to attribute such poverty to the political and economic system).

Unfortunately, the reverse seems to be happening: the present economic and environmental crises, with their roots in the financial innovations of New York's Wall Street and the City of London, and the uncontrolled and expanding reach of speculative capital over the past two to three decades, are triggering resurgent declarations that it is the too many people of the world (or rather those in the Third World) that constitute the major problem. The tragic consequences of this financial crisis—millions losing their jobs and livelihoods, becoming destitute and going hungry—are

already being laid at Malthus's door in astonishingly protean forms of argument.

In 2008, for instance, there were more and more food riots in countries ranging from Mexico to Morocco, Uzbekistan to Bangladesh, the Philippines to Indonesia, as financial speculators gambled on the prices of food going up. In Pakistan and Thailand, troops were called in to guard godowns storing food. The President of the World Bank—one of the institutions that has actively supported the patterns of trade and investments responsible for the crisis in the first place—estimates that the current food crisis will send a hundred million more people deeper into poverty (Ghosh 2008). Despite a decline in population growth in both India and China, per capita food availability has sharply declined. In India, per capita annual food grain absorption has declined from 178 kilogram in 1991 to 154 kilogram in 2004 even as India exported grain for consumption as animal feed in the West (Patnaik 2004). Between 1998 and 2005, 9,000 farmers are officially reported to have committed suicide. Half of India's rural population has a food intake below that of sub-Saharan African countries. Utilizing the norm of 2,400 calories as required daily calorie intake, three-quarters of India's rural people could be classified as poor in 1999–2000. These are the direct consequences of state policies followed since India embarked upon its neo-liberal reforms in 1991. Yet India's Supreme Court, "appalled by the indifference of the states . . . to the problem of food", has issued notices to state governments asking what steps they are taking to tackle the "demographic explosion" (Mohapatra 2009).

Meanwhile, although birth rates in some European countries have reached unprecedented lows, people in France and Italy have voted in governments with an explicitly anti-immigration agenda. After a spate of immigrant attacks and killings in Italy, some of the country's regions have banned the manufacture and sale of "kebabs and other foreign foods" because they eat into the businesses of "natives". President Silvio Berlusconi's government passed a law in February 2009 obliging doctors to report to the authorities any illegal immigrants coming to them for treatment. The government has claimed that immigrants commit 35 percent of all crimes in Italy (Navarane 2009).

France, meanwhile, seems to believe that its more robust birth rates (a mini baby boom compared to those of Germany and Italy) will help it

ride out the recession; indeed French economists believe that the boom "could well be the country's secret weapon to cope with the current crisis" (Betts 2009: 22), because more children means more consumer spending and more younger people means more workers. As opposition to neo-liberal policies marked by welfare cuts grows, tax breaks are given for families with three children or more while state funding means that childcare is readily accessible from the earliest age—all policies that fly in the face of the neo-liberal logic that President Sarkozy espouses. France's suburban unrest, meanwhile, has been blamed on Muslim immigrants and an Islamic desire to convert Europe into Arabistan.

In cases such as these where population and "race" intertwine, a strange and dangerous alchemy is invariably at work, or at least taken advantage of. In February 2009, for instance, British newspapers described how workers at energy facilities were going on impromptu "wildcat" strikes because an Italian firm operating in the UK was bringing in Italian and Portuguese workers to fill the jobs. The media emphasized the loss of jobs to "foreigners"—who were not the Blacks or Browns and Yellows so familiar in racist discourse—and some workers endorsed the "British jobs for British workers" slogan put forward by Prime Minister Gordon Brown in 2007. Lost from the story, however, was the main reason why workers were protesting: nationally-agreed rates of pay were being undercut with the support of the British government. By obscuring mobilization for labor rights, the far-right British Nationalist Party (BNP, which has been described as fostering hatred of immigrants and ethnic minorities) has been whipping up anti-immigrant sentiments among unemployed workers, infiltrating workers' meetings and posing as strike organizers (Suroor 2009). Recession and industrial discontent provide a fillip and cover for the likes of the BNP (Guthrie 2009).

The government of Russia, faced with one of the most precipitous de-clines in population ever recorded, has reduced the marriage age for *girls* to 16 without parental permission and 14 with permission, while also making abortion increasingly difficult to obtain.

In short, as the global economic crisis worsens, one automatic response has been over-determined. Population growth of the "Other" has always been an easily-available explanation that can be called upon. Scapegoat-ing and blaming the "Other" serves once again to deflect attention from tackling the privilege of the few and obscures some of the real roots of

the crisis. This automatic reaction always comes with some select facts to back it up, and always appeals to the worst in us, never the best. Above all, elites across the world proffer this explanation, which the media reflects and textbooks endlessly and convincingly repeat. As Göran Therborn has written, "demographic arguments have since Malthus been used as a club of raw biology with which to batter down hopes of popular rights and coexistence" (Therborn 2009: 144).

If the ongoing economic crisis brings reminders of the 1930s economic depression, it also revives memories of other policies and practices of that era—pro-natalism for some groups, sterilization and killing of others. It should be a matter of grave concern, therefore, that "the world is experiencing a vengeful return of ideas that flourished before 1945, with the same scorn for the uncivilized, for lesser breeds, for the rights of other peoples" (ibid.).

All this suggests that the time is more than ripe to assess not only the 1994 ICPD's Programme of Action, but also what has happened in the intervening years. Was the ICPD really a paradigm shift, or was it simply population control in a new avatar? Or was it a marriage of multinational feminisms with international debt? Given that neo-liberal policies have been pursued uniformly across the globe, how have collapsing health structures responded to this supposed paradigm shift? What exactly did reproductive choice mean? Was it even possible to assure populations' reproductive health and rights when their livelihoods were being assaulted by neo-liberal macro-economic regimes under which access to the fundamental determinants of health was being eroded?

Is the subsequent fundamentalist backlash against the Programme of Action indicative of the political pendulum swinging back, as is often the case in the ebb and flow of political gains and losses? Or were the Programme of Action and its accompanying feminist organizing in fact not as positive as all the euphoria that greeted it may have suggested?

Was feminist discourse simply co-opted by development jargon to suit a brave new neo-liberal world? Did reproductive rights come divested of rights to food, employment, water, health care, and security of children's lives? Were the Cairo agenda and the women's organizing incidental to the neo-liberal debacle that is so clear today? Could the agenda have been less of a revolution and more of a compromise that aided and abetted these other forces?

With the obvious benefit of hindsight, this volume explores all these questions. It attempts to address the politics of neo-Malthusianism that led to and formed the heart of the Cairo agenda in 1994 and reassesses the political organizing around it. It looks where population policies, reproductive health and rights, and population thinking are today in the 16 years since the significant accord. It explores what the years since Cairo have meant for everyday lives for people, for women in particular, and for health and population policies. As the fundamentalist backlash against Cairo intensifies, there is a tendency to remember only the positive aspects and forget the negative. In the process, important lessons of that complex historical moment are easily lost, lessons that have continuing relevance today.

The focus of this volume is the range of discourses that went into Cairo and their trajectories since. The chapters are wide-ranging (although not, of course, comprehensive) in geographical coverage and theme, but several threads emerge repeatedly. A key one is the role that the neo-liberal economic framework has played in deteriorating health conditions around the world. The Programme of Action, and the feminist organizing that accompanied it, largely ignored this framework, as Sarah Sexton and Sumati Nair document in this volume. Their chapter provides an overview of the ICPD and its "marriage"—or was it a compromise?—with neo-liberalism that ultimately served to wreck it. The Programme of Action certainly promoted women's rights and reproductive rights but only within the context and parameters of the dominant neo-liberal agenda, which has had a massive negative impact on women's lives and health around the world. This huge fault line not only blocked any real progress in transforming the reproductive and sexual health/rights agenda from noble rhetoric into actual policies and services; it also rendered it irrelevant to the needs of the majority of women in the world.

Betsy Hartmann's chapter provides new data on other "marriages", those between security agendas, the population control establishment, and an influential section of the feminist movement. Together they served to influence the global agenda of reproductive rights that came to the fore at Cairo. Although US security concerns have always underpinned the country's involvement in population issues, the end of the Cold War in the late 1980s forced a redefinition of this security agenda. Environmental problems ranging from nuclear contamination to soil degradation were

recast now as major potential security threats. A model of "environmental conflict" supposedly arising from these problems—too many poor people causing environmental degradation, migration, and violent conflict—provided a neat causal reasoning to allow continued US intervention and surveillance around the world. Emphasizing the role of migration, attributed to too many people in certain countries, has been a key link in this causal chain that has meshed well with anti-immigrant sentiment in the USA.

By the early 1990s, as preparations for the ICPD were underway, concerns about environmentally-induced conflict accelerated and came to dominate the rethinking of security. The model of "environmental conflict" that drew heavily on neo-Malthusian assumptions about the relationship between population and the environment was also actively supported and promoted by powerful private population-oriented US foundations and senior government officials. Thus followed an uneasy alliance with bourgeois women's groups in drafting the Cairo agenda; reproductive health became a convenient portmanteau not only for the population control lobby and an influential section of Western feminist groups, but also for the security establishment.

Marlene Fried examines the politics of abortion that came to dominate reified ideas—should one say conceptions?—of reproduction at the 1994 ICPD, and the trajectory of abortion politics in the US since then. It is well known that these politics cast their shadow across the globe. The US "global gag rule" has meant that funds for reproductive health programs in recipient countries have dried up if these programs also offer services for abortion.[7]

Fried emphasizes that the idea of choice, so dear to many a feminist as it was a clarion call from women's movements in the West to gain access to abortion in the 1960s and 1970s, also invokes the marketplace: only things that are for sale can be chosen. "Choice", she points out, appeals to those who have options, but is relatively meaningless to those who do not, and is thus politically divisive. The neo-liberal notion of choice, moreover, locates rights within an individual and thus obscures the social context and conditions needed in order for someone to have and exercise her rights. It individualizes social problems by attaching them to an individual body as a "risk calculus" and then focuses on an individual's preventive behavior, ignoring the social problems behind the risk and the

social causes of that problem. Thus, what were once progressive notions or slogans of "self-determination" or "women decide" now mesh well with neo-liberal individualism.

Within the United States, women of color are expanding the understanding of reproductive rights so as to link the struggle for abortion rights (a struggle they wage outside of the choice framework) to other health and social justice movements working against overarching socio-economic inequalities and racism. In so doing, they have transformed reproductive rights into reproductive justice.

What has now become profoundly problematic with the choice framework is also evident in discourses attached to reproductive technologies such as in vitro fertilization (IVF), technologies that are invariably portrayed as a prerogative of and enabling women to exercise choice. But ignoring the context in which women have to make decisions means that "choice" of any sort may not necessarily be liberating.

In India and China, the unregulated and widespread use of ultrasound illustrates the intersections and intermingling of reproductive technologies that are often thought of as providing choice—for instance, to determine the sex of the child—with neo-Malthusian population thinking. If parents are allowed or want only one or two children, many will endeavor to ensure that their children are of the "quality" and sex that they perceive are needed or desired.

A ready market—enlarged by the medical profession—for technologies assisting or encouraging reproduction is also created when women's role and status is still determined by child bearing, and preferably son-bearing. Thus IVF clinics are flourishing in India, while embryonic stem cell technologies, which need women's fertile bodies for their raw source material, are thriving in both China and India, countries that in the population discourse are construed of as needing to discourage women's fertility rather than encourage it.

The anthropologist Aditya Bharadwaj, who has studied India's IVF industry for the past decade, recalls one woman who feared being abandoned by her husband, and thus reduced to poverty, saying to an IVF doctor, "I will do anything if you can give me a child. I will give you my kidney. Just let me get pregnant" (Bharadwaj 2006). Joining the existing trade in human organs such as kidneys is a steady supply of semen, eggs, embryos, and stem cells derived from embryos to Western Europe. Fried's chapter focuses on abortion, but her critique of choice is just as relevant

here. And just as the Programme of Action was silent on the neo-liberal economic trends evolving all around, so, too, it paid little heed to the consequences of new reproductive technologies.

Disability rights activists have long highlighted how new reproductive and genetic technologies can be used not to eliminate certain unwanted traits but simply to eliminate people. They have shown repeatedly how disability is largely socially constructed—if there are ramps and lifts, for instance, most people are not disabled; if there are only stairs, many people are, and not merely those with physical disabilities they were born with. By far the majority of physical and mental disabilities are acquired after birth and are not genetic or inherited. The disability movement has also raised fundamental questions regarding rights, particularly individual and community rights, which come up time and again in debates on population and on women's rights. Who has the right to determine who is to be born? Parents, an individual, a community, or indeed, the nation-state? Here, these discourses merge somewhat ambiguously with those of the anti-abortion lobby.

Mohan Rao's chapter provides some important details that are largely missing from the Cairo discourse by exploring links between neo-liberalism, neo-Malthusianism, and the politics of identity. Population politics and fundamentalisms now intertwine in strange and frightening ways. He highlights the fundamentalist Hindutva proclamations in India of "too many Muslims" that serve to justify their calls for Hindus to ignore the country's family planning program and have more children. Such arguments have underpinned vicious anti-Muslim pogroms in India in recent years, one of the most horrific being in Gujarat in 2002. But this is not restricted to India alone, as citizenship is fractured in many countries, as in Yugoslavia or Rwanda. Overpopulation, this time of the numbers of the "Other", is a virulently constructed political threat that has lead to ethnic cleansings. Neo-Malthusianism, along with neo-liberalism, naturalizes this political construct, or attributes it to irreconcilable cultural differences, which in turn get naturalized.

Rachel Simon-Kumar's chapter highlights how the politics of discourses can blind us to facts of more of the same. For instance, a politics stressing that "the personal is political" has served at times to trivialize politics, even as it reinforced existing patterns of power and of access to resources. Her chapter also addresses the deep interconnections

between today's population policies and neo-liberalism, but from another perspective. She focuses on the relationship between women, the contemporary neo-liberal state and reproduction to ask whether it is possible for neo-liberal states to transform social and economic conditions so as to advance women's reproductive interests. She illustrates her analysis with reference to India, where dramatic changes took place in the 1990s in both population policies and economic policies.

Kumar describes the beliefs underlying conceptions of a neo-liberal citizen—that individuals are solely responsible for their prosperity and welfare, or lack of it—in ways that the originator of population thinking, Thomas Malthus, would easily recognize. Although best remembered for his 1789 *Essay*, his goal was in fact to legitimize private property rights and to argue against welfare, issues that are poignantly current today (Lohmann 2003; Ross 2000).

It is not surprising, Kumar concludes, that neo-liberalism has become deeply enmeshed with debates on eugenics, heterosexuality, racism, and anti-feminist fundamentalism—all key facets historically of population policies. Kumar's analysis is strikingly relevant for anxious constructions of gender and citizenship in the 21st century as individual responsibility and blame are heavily laden, indeed overdetermined, with a biological interpretation.

Martha Rosenberg's chapter draws attention to the changing political context in Latin America in the 1980s and early 1990s, as many countries in the region overthrew long-standing military dictatorships and instituted elected democratic governments. Linking with the new democratic governments was a positive and welcome change as feminist movements gained in confidence and focused on state-oriented gender policies. Rosenberg's focus on population policies in Latin America over the past two decades draws attention to a dilemma that has long confronted NGOs and social movements: whether to work with and within a government or outside it.

In the 1980s, many Latin American women's movements took up the discourse of rights as a cornerstone of their political projects. As part of the democratization of society, the right to self-determination, birth control, and abortion became basic components of the feminist agenda in a region where both had been proscribed for many decades. In many Latin American countries, population policies had not been anti-natalist,

as across Asia, but pro-natalist ones backed by military, nationalist, and Catholic agendas. The Programme of Action emanating from the ICPD thus afforded these groups creative political space to make surprising and significant gains. Yet profound questions, even doubts, remain, as neo-liberalism eroded the lives and livelihoods of people over the same period in other significant ways.

Susanne Schultz, in her analysis of population policies and the changing approaches of women's NGOs in Latin American countries, indicates how external funding, particularly from the United States, has been critical for population policies in these countries. For instance, international population agencies provided more funding for Peru's population policy in the latter half of the 1990s than for any other Latin American country, even as the family planning program in this country was remarkably coercive. The USA also provided the major funding for women's groups and health groups backing reproductive rights. Thus even as they battle for reproductive health and rights, many of these so-called civil society organizations end up being clearly linked to the neo-liberal international economic agenda. Donor agencies are renowned for being highly selective in their funding choices. United States Agency for International Development (USAID), in particular, tends to support only those NGOs that echo its priorities. Such NGOs have thus become the conduits through which the internationally sponsored family planning program came to establish itself outside the realm of governmental control (a theme also addressed by Kamran Asdar Ali in Egypt in this volume). Indeed, the phenomenal growth of NGOs in these neo-liberal times could perhaps be described as their metastasis.

As both Rosenberg and Schultz show, the trend toward democracy in Latin America in the 1980s and 1990s coincided with the expansion of capitalist globalization in the region (and of market fundamentalisms globally). As a result of the two processes coinciding, people in general, but especially women, gained more rights as a result of the ICPD—but the conditions in which to exercise them worsened. Neo-liberal policies have increased women's absolute and relative poverty because they have increased women's workload as public expenditure on health has been reduced, and unemployment has increased. Uncontrolled commercialization of all fields of activity has eroded much of the region's social fabric. In their organizing around the ICPD, the women's movement

did not make a commitment to challenge the so-called development criteria being taken for granted in Cairo.

Kamran Asdar Ali's chapter stresses that Egypt's population program needs to be understood as a corollary to the structural changes in the Egyptian economy implemented in the early 1990s. The Egyptian state, under international pressure to make it more market-oriented, undertook the familiar package of privatizing key industries and dismantling even weak and half-hearted efforts toward a welfare state. As a not-unfamiliar consequence, levels of unemployment and under-employment increased remarkably, even as real incomes fell amid the working population. A reduction in the population's size was considered one way to reduce government expenditure on education, health care, and jobs—and to justify such reductions. If structural adjustment was supposed to cut excess in the economy, Asdar Ali argues with a striking metaphor, the family planning program was presumed to guarantee a correspondingly lean family. Removing state welfare, it was believed, would persuade families to adopt family planning as a voluntary and non-coercive choice. Yet far from bringing choice of any kind or freedom, he contends that the state's public health and family planning campaigns, austerity measures, political violence, and police aggression have simply coerced people into being non-citizens, some more compliant with their fate than others.

At the same time, of course, fundamentalism grows in Egypt, too. Both in the USA and elsewhere, Islamic fundamentalism, immigration, and terrorism are all linked together and attributed to there being too many people. Asdar Ali points out that the Egyptian news media is full of reports of the state's violent engagement with Islamist groups as attacks on "terrorist violence"—yet seldom analyzed is the social and economic violence of poverty and lack of amenities suffered by the Egyptian poor. Many Egyptians thus viewed overpopulation as a contrived social issue. They implicitly critiqued the internationally sponsored family planning program, based as it is on the thesis of limited assets within given borders of a nation-state while ignoring arguments for local or international redistribution of resources.

Meredeth Turshen mobilizes a vast array of data to reinforce pictures of health in Africa in the years since Cairo. Rather than condemning governments for their lack of attention to health care provision, however, she points out that public spending on health care is catastrophically low, thanks to the World Bank-imposed structural adjustment programs that

cut public services and health worker salaries, and introduced "user fees" for services. Africans, she stresses, now spend proportionately more on out-of-pocket health care than US Americans. It's not surprising that African governments have not met their ICPD goals relating to family planning availability, AIDS or female literacy.

The health cutbacks have acted in concert with other related trends to reverse health gains in Africa. Turshen highlights brain drain, from rural to urban areas, from primary to tertiary facilities, from public to private, and from poorer countries to richer ones. She also points the finger at phantom aid: aid from donor countries that is wasted, misdirected, or recycled within the richer countries themselves. Critically, she indicates the dramatic increase in poverty across the continent. To answer why Africans cannot afford public health systems is to ask why Africa is regularly dispossessed and drained of its wealth.

Lisa Ann Richey's chapter also focuses on Africa in her analyzes of how reproductive health and population policies intersect with AIDS policies in Uganda and Tanzania. Since the ICPD, the issue of HIV/AIDS has taken up more public attention and funding than reproductive health programs despite the Cairo commitments (Bandarage 1997). The two issues tend to be conceptualized quite independently: AIDS is seen as a problem of lovers; pregnancy, one of mothers. One consequence is that separate HIV/AIDS and family planning vertical programs are common throughout Africa, and are often regarded as competing with each other, not least for funding.

As a result, both policies and programs actively work to undermine each other, concludes Richey, and neither serves women's needs. Run as vertical programs, they do not strengthen collapsing public health services. Above all, they ignore what public health's *raison d' être* is: attend to the determinants of diseases, even as you cure. In Africa, she notes, reproductive health has focused more on "reproduction" than on "health"; although this could indeed be said, and said loudly, of all the countries considered in this volume.

What the focus on AIDS has done, however, is to bring issues of gender and sexuality to the fore in debates and decisions that have until now been dominated by functional explanations of how contraceptives can bring down population growth. It is gender-sensitive academics and AIDS activists rather than population policies and their opponents who have promoted openness about gender, including sexual and domestic violence, and links between gender oppression and poverty.

Yet there is more critical work to be done in exploring the intersections between sexuality and the politics of population and of reproduction. While some lesbian and gay movements feel that a population discourse focused on limiting births, with all its unspoken and unaddressed heterosexual and masculine assumptions and biases, has little to do with them, it is in the morphing of such discourses with those of reproductive rights that uncomfortable disjunctures may emerge. As reproductive rights become reified, commercialized, even commoditized, for instance, they are used to justify lesbian and gay couples having their "own" biological children, even if this means paying other women to out-source their uteri or eggs, or men their sperm.

Susan Greenhalgh's chapter illustrates how China's one-child policy completely ignored gender dynamics in the country, especially in rural areas. Enforced in a masculinist culture and political-economy, the sharp restrictions on childbearing had damaging, if not lethal, consequences for girls because boys were the children who counted. Moreover, China's population policy has assumed, and left unchallenged, many patriarchal masculine prerogatives. Aggregate statistics indicate that it is women who have borne the great burden of sterilization and contraception. Beneath the gendered numbers lie pervasive cultural and economic attitudes affirming male superiority, male entitlement to sex, and male prerogative in protecting the body from risk. As a result, the birth program left many women with short and long-term physical problems and deep psychological wounds that reflect and worsen their low status in deeply patriarchal China.

Women in China today have far fewer children than their mothers and grandmothers, but every aspect of reproduction—from spouse selection to marriage, contraception, childbearing, and child rearing—has now become the object of state concern, albeit now intensely abetted by the market. Indeed, it is now difficult to determine which plays the greater role. The one child the state allows is to be provided with the best the market, including McDonald's, can offer. The politics of population quality is now deeply infused with the market logics of individual consumer desire and global consumption fantasy—a fantasy to become a global person through the consumption of foreign products.

As family or "private" politics became public politics focused on women's bodies, so women's bodies became the targets of intense surveillance, intervention, and control. In this respect, it would seem that

little has changed from earlier population policies. What this has also led to is intense daughter avoidance and dramatically skewed sex ratios. As already mentioned, India and China are similar in this anti-feminist respect as they mesh ever closer with neo-liberalism.

The volume is ambitious in its coverage of themes, discourses, and the empirical, but has admittedly some significant lacunae, such as those on disability, sexuality, and newer reproductive technologies. One fact we are aware of is that while we have an admirable range of contributors, the majority of them are located in the First World. This is not to suggest that their ideology and politics is colored by neo-colonial (post-colonial?) neo-Orientalism of much of the First World, and indeed Third World, academia, but precisely the opposite. But the politics of residence and of neo-imperialist domination of academia—or activism—is nevertheless germane.

Despite these lacunae, the chapters in this volume are a powerful re- minder that population policy has always been, at root, an economic and social policy, about the role of the state and markets, about race and gender, above all about class and power, between the First World and the Third, between elites and others within countries, above all about who uses resources. It is these issues that have not gone away in the 16 years since the 1994 International Conference on Population and Development. It is these questions that remain to be answered and tackled with an urgency that has only increased in the second millennium.

ACKNOWLEDGMENTS

NOTES

1. *Population and Global Warming Factsheet,* US Sierra Club http://www.sierraclub. org/population/reports/globalwarming.asp (accessed on April 21, 2008).
2. Malthusian links with India are thick, pervasive, and continuing. While there is quite a lot of literature on how Malthusian thinking influenced famine policy in India in the

19th-century famines that devastated the countryside, for example, withholding relief from the starving, and on how neo-Malthusian ideas continue to influence health and population policy in India today, what is less well known is that, in a sense, India helped to make Malthus the figure he is: he was the first Chair of Political Economy at the East India Company's College in Britain that trained India's future administrators.

3. While Matthew Connelly provides an excellent description of the population control story, his historical account is mistaken where he assumes that the institutions that have long been the tigers of the population control movement changed their stripes in 1994 at the Cairo conference.

4. For distinctions between a population program and a reproductive health program, see (Hartmann 1995: 57–58).

5. The *National Health Policy* of India notes, for example, that families are typically cutting down on nutritional needs to meet medical and health expenses.

6. A vertical health program is a way of structuring the planning, management, and delivery of a single health care intervention (such as immunization, control against diarrhea or tuberculosis, or family planning) that is not integrated with other health activities. Vertical programs enable funders to control and monitor their investments more easily through quantitative targets, such as the number of children immunized. Vertical programs can be effective in meeting a narrow, pre-set objective, but tend to fragment and duplicate health systems into self-contained units.

   Vertical disease programs disaggregate some diseases from others and from the health care system, thereby undermining attempts to address interlinked and underlying causes. For instance, communicable diseases (such as malaria, tuberculosis, and leprosy) are one of the outcomes of malnutrition and causes of reproductive ill health. International attention to some communicable diseases has increased in recent years because of the resurgence and spread in the last two decades of old and new diseases, such as cholera, tuberculosis, malaria, yellow fever, trypanosomiasis, dengue, and HIV/AIDS, particularly among poorer people. A contributing factor to the increase, however, has been the disruption of infectious disease control programs, for instance, in sub-Saharan Africa and India, because of cutbacks in public expenditure. Before 1960, control of communicable diseases accounted for nearly 30 percent of India's public health budget; now it is down to 4 percent.

   Most international efforts to tackle communicable diseases now focus on supplying new medicines within vertical, time-limited programs accompanied by a range of financial and policy conditions (such as implementing international intellectual property rules). They pay little attention to strengthening basic health services or to preventive and public health measures. Besides medication, control of diseases such as HIV/AIDS, tuberculosis, and malaria requires improved living and working conditions, well-functioning health systems, strong coordination between different sectors, and community mobilization.

7. The "global gag rule" prohibits US government aid going to an entity that provides or makes referrals for abortions, actively promotes abortion, or lobbies for reform of its country's abortion laws. The rule was first signed by President Ronald Reagan in 1984 after the UN's population conference in Mexico, suspended by President Bill Clinton almost a decade later, and reimposed by President George W. Bush in 2001 as his first

official presidential act. President Barack Obama rescinded it on January 23, 2009, but it should be noted that in February 2009, the state legislature of North Dakota passed the first "Personhood Bill". This states that, as far as North Dakota's constitution and laws are concerned, an individual, person or human being "includes any organism with the genome of homo sapiens", thereby granting rights to fetuses the moment a human egg is fertilized. Similar bills have been introduced in another four US states. The Supreme Court's 1973 decision in the *Roe vs. Wade* legal case, upon which legal abortion rights in the USA depend, acknowledged that the "fetus" is fully human, but did not grant the rights of "persons" until birth.

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2

A Decade and More after Cairo: Women's Health in a Free Market Economy*

Sarah Sexton and Sumati Nair

The 1994 UN International Conference on Population and Development in Cairo was heralded as a "quantum leap" forward (comment made by UNFPA Executive Director Nafis Sadik, cited in McIntosh and Finkle 1995: 224) and a "paradigm shift in the discourse about population and development" (Presser and Sen 2000: 3). Its Programme of Action was the first and most comprehensive international policy document to promote the concepts of reproductive rights and reproductive health. Its major recommendation was that population programs should provide comprehensive reproductive health services that were integrated and coordinated with each other and with other health services. It put women at its center and expressly rejected the use of incentives and targets in family planning services.

Over a decade later, however, the general consensus is that the Programme of Action is still far from being implemented. This has been variously attributed to lack of political will on the part of governments or lack of donor funding. But other forces are also at work. Health services in many countries are in decline or have collapsed. The underlying conditions determining women's health and their control over childbearing are deteriorating. Fundamentalisms opposing women's rights are on the rise. And neo-Malthusian thinking is as ingrained as ever in many development institutions, donor agencies, and government departments.

As a result, many positive trends in the health of women and children the world over have been reversed, while reproductive health and rights remain threatened, particularly for poorer women, migrant women, and women of color.

These negative forces can be attributed in large part to the implementation of neo-liberal economic and health policies over the past two decades, first by means of structural adjustment programs (SAPs) and more recently by international "free" trade agreements and national-level policies. The Programme of Action, together with the accompanying political organizing by international women's organizations and population groups, did not challenge neo-liberalism sufficiently, but endorsed it in several respects. It thereby undermined its groundbreaking principles and goals of reproductive health.

CONSTRUCTING COMMON GROUND

For the past 50 years and more, Western-educated or influenced elites, governments, institutions, and aid agencies have variously attributed a range of major social problems—poverty, environmental degradation, slow economic growth, hunger, war and conflict, threats to Northern security, unemployment, or international migration—to the increasing number of people in the world, particularly those who are darker-skinned, poorer or from the countries of the South. Reducing population growth by reducing the number of babies women give birth to has been their chosen solution. Of all the development, economic, environment, or social policies devised by think-tanks, implemented by governments and funded by multilateral agencies, population policies tend to be the only ones that primarily focus on women from the outset rather than subsequently tacking on gender-oriented amendments under pressure from women's movements.

In the early 1990s, some women's health groups decided to attempt to influence the direction and outcome of the proposed 1994 UN International Conference on Population and Development (ICPD) so as to get governments to encompass reproductive rights and gender equity within their population policies. To do so, they looked for "common ground" with population organizations, governments, and donor agencies. This meant that if they could not countenance straightforward attempts to lower women's fertility, neither could they dismiss "the population problem".

Several women thus outlined the resulting "feminist population policy" (see, for example, Dixon-Mueller 1993). This presented "population stabilization" as a desirable ultimate goal, but one that did not warrant the use of compulsion; justified national population programs providing access to contraception in terms of individual human rights and women's health; and presented women's empowerment as a prerequisite for the enduring low fertility that population stabilization requires.[1]

A key player developing and promoting the combination of a neo-Malthusian agenda to reduce fertility rates and a reproductive rights agenda to influence the ICPD was the International Women's Health Coalition (IWHC).[2] To build an alliance between neo-Malthusians and feminists, the IWHC circulated "Women's Voices '94: Women's Declaration on Population Policies", a statement drawn up by 25 individuals from a range of women's organizations outlining the conditions to be met if women's reproductive health and rights were to be realized ("Women's Voices '94" 1993).

The Declaration's goals were largely uncontroversial: better health for women and children, women's rights, more justice and equality, less poverty, better social, sanitary, and transportation infrastructure, education, and reproductive health programs for men. Its calls for reproductive health and rights, however, were deliberately made within a population framework so that the Declaration could "be used as a tool to influence governments and international agencies" and give the impression of a "political front" comprising a wide range of women's groups worldwide who were ready to act "within the official (ICPD) process at international and national levels" (Antrobus et al. Unpublished manuscript: 2).[3] Although many women's groups, then, as now, were not concerned about reducing population levels, several more mainstream groups accepted the premise that population growth was the root cause of several problems, and that women's fertility would go unchecked without outside intervention, even while they criticized population policies' insensitivity to women. The Declaration's initiators "sidelined [those] radical feminist views" that were critical of making demands for reproductive health within a population reduction framework (McIntosh and Finkle 1995: 239) and marginalized those organizations and individuals that refused to sign the Declaration.[4]

The Declaration's organizers also made concerted efforts to draw support from population organizations (most of which are US-based)[5]

as well as governments and international agencies such as the United Nations Population Fund (UNFPA). Many of these institutions were open to the idea of a "feminist population policy" because they had begun to acknowledge that coercion, mistreatment, and poor services were driving women away from family planning clinics. Progressive demographers and bureaucrats, many of them women steeped in feminist ideals, wanted to improve family planning programs and the quality of care that women received. By the early 1990s, a wide network of women in the South as well as the North in high-level policy and management positions in foundations, non-governmental organizations, and national and international agencies focusing on "population" conceded that education and jobs were as important, if not more so, in reducing women's fertility than modern contraception.

Many were also aware that if Cold War fears had generated political support for population reduction efforts, the collapse of the Soviet Union had dissipated it, and that an increasingly powerful "religious right" in the United States was opposed to abortion, contraception, and women's rights more generally. Hodgson and Cotts Watkins argue that:

> Neo-Malthusians reacted to declining interest by reshaping their agenda and . . . by pragmatically casting around for possible allies . . . The new alliance that came to sustain the neo-Malthusian movement was with feminists, and was indeed largely initiated by feminists. (1997: 496–97)

It was not that "tactical compromises and unholy alliances" with "mainstream population organizations or neoliberal governments" (Petchesky 2003: 50; Silliman 1999: 133–62) were hard for the women's movement to avoid: they were actively sought out by some groups.[6] One advantage to population groups of this alliance was that the critiques of feminists, among their most vocal critics, appeared more muted.[7]

The upshot was that many (but not all) population groups saw the advantage of abandoning demographic targets for national population policies (though not of dropping the goal of reducing women's overall fertility). They accepted that until women's status improved, population reduction was unlikely. They agreed that a gender equity strategy could stabilize population levels, and that family planning activities should be supplemented with reproductive health ones, even if this implied that the costs of population programs would increase.

The Women's Declaration was eventually endorsed by some 2,200 organizations and individuals, including the Population Council, the International Planned Parenthood Federation, and some 100 women's organizations in 23 countries. As the president of Population Action International, Joseph Speidel, observed in 1994:

> . . . there is growing recognition that there's a tremendous amount of common ground among what's been loosely called the health advocates, coming from a more feminist perspective, and traditional family planners, who come from more of a demography, environment, and development perspective. (Hodgson and Watkins 1997: 502)

Hodgson and Cotts Watkins further point out that:

> By the time delegates met at the 1994 ICPD meeting in Cairo, a group of American reproductive health feminists had been successful in uniting a large bloc of feminists and much of the population establishment behind the carefully constructed "common ground" agenda. (ibid.: 503)

US private funders were also instrumental in creating, promoting, and funding this "common ground" agenda. Notable was the Pew Charitable Trusts (a private foundation based in Philadelphia and the largest environmental grant-maker in the United States) but the other important organizations included the Ford, MacArthur, Hewlett, Mellon, and Rockefeller foundations (Hartmann 1995: 120, 148–51), many of which had been major funders of the population control efforts in the South. Yet, despite the salience of the issues raised throughout the ICPD process to the United States, the Cairo consensus had little positive impact within the country itself.

The resulting Programme of Action (POA) from the Cairo ICPD clearly reflects this organizing background. It put women at its center, rejected the use of incentives and targets in family planning services, and stressed the need for comprehensive reproductive health services. But its ultimate goal is "population stabilization" and regards women's empowerment as essential for the low fertility that this requires.

A FEW HEALTH SERVICES FOR THE FEW

The POA undermined itself in other key areas, too. Since the 1994 ICPD, for example, most family planning programs have not broadened to

become reproductive health services provided within primary health care systems as the POA called for. This is largely because of pressures put on governments to reduce their spending and their provision of services under the rubric of structural adjustment programs and their successors. The (usually unregulated) private sector cannot fill the gap: the commercial sector finds it unprofitable to do so, while the non-profit sector does not have the resources to handle the job (Silliman 1999). As a result, evidence from around the world indicates that many women still have little or no access to reproductive health services, or even any decent health services at all, because they are not provided or are not affordable.

Even before the Cairo Conference, however, influential policymakers such as the World Bank were urging cuts in public health services, the introduction of "user fees" for the public services that remained, and incentives to create a "free market" in the health care sector (Mackintosh 2003).[8] The World Bank's 1993 World Development Report, *Investing in Health* (note the title), proposed that the public sector should only provide essential services as "clinical packages" for the needy and that governments should open up the rest to full global competition. A market-based approach to health not only drives up the costs of health care, but can also lead to lack of interest in the factors that make people ill. It promises (falsely) that medical technology can fix diseased individuals, and that good health can be bought and sold in the marketplace rather than being something to promote or work for. In many instances, the private health care sector does not provide a higher quality of care, nor is it more economically responsible and efficient.

The Programme of Action went along all too readily with the World Bank's neo-liberal economic approach to the detriment of its rights agenda. For instance, it urged governments to introduce user fees in health services and social marketing schemes aimed at distributing contraceptives. However, the widespread promotion and over-the-counter sales of contraceptive methods for which women should be medically screened and monitored can be problematic. Without medical follow-up contraceptive users, especially those who are anemic or malnourished, could experience unpleasant, if not dangerous side effects, undermining in the longer-term their health and well-being of their children. The POA encouraged governments to "promote the role of the private sector in service delivery and in the production and distribution . . . of high-quality

reproductive health and family planning commodities and contraceptives" (ICPD Programme of Action 1994a), and urged countries to "review legal, regulatory and import policies . . . that unnecessarily prevent or restrict the greater involvement of the private sector" (ICPD Programme of Action 1994b). It recommended that the bulk of available resources should be allocated to family planning within publicly supported services while the market should be relied upon for everything else.

The basic package of health services that many public health systems now attempt to provide—family planning (primarily to women), prevention and treatment of sexually-transmitted diseases, child health, control of communicable diseases, and treatment of some diseases—is much narrower than even the essential services outlined in the Programme of Action.[9] The goal of gender equality, women's empowerment, and reproductive and sexual health has been conspicuously absent in these various "reforms" of the health sector. Governments may subsidize family planning services, but, because they have cut back on physician services, or the training of nurses and midwives, many women now receive contraceptives without medical supervision.

Several studies suggest that user fees have resulted in decreased use of public health services, especially by poorer people and women, leading to a rise in maternal and infant mortality rates (Nanda 2000, 2002). In Zimbabwe, Tanzania, and Nigeria, for instance, user fees have been linked to a marked fall in women's attendance at ante-natal clinics and a doubling in rates of women dying in childbirth. User fees come on top of other costs, such as a wide range of informal, illicit payments to health staff—effectively subsidies to underpaid health workers—and medicines, food, equipment, and transport to hospital. Out-of-pocket expenditures by individuals and families now account for more than half of health care spending in many countries. As a result, families are going into debt, consuming less food, or taking girls out of school. Many people simply do not use health care services at all, and it is women of reproductive age who are most likely to leave untreated conditions, such as reproductive tract infections, that are chronic but not incapacitating, contributing to greater disease and cost burdens at a later stage.

In many areas, there are no primary health care facilities left through which reproductive health care services could be implemented, or those that exist are in a disorderly mess. One study concluded that "economic

reforms" were the "paramount constraints in implementing the ICPD Programme", particularly in expanding reproductive health services (Sadasivam 1999: 10).

Because of the systematic erosion of primary health care systems over the years, many governments, with the support of international financial institutions and aid agencies, now rely more on NGOs to deliver reproductive health services. Today, NGOs deliver more official development assistance than the entire UN system (excluding the World Bank and IMF). In the process, many women's and other NGOs may have unwittingly helped to enable the privatization and liberalization of economies and services and left themselves with less energy for political advocacy. Many NGOs have become more accountable to foreign donors than to the people they are meant to serve. Asdar Ali notes that in Egypt, for example, NGOs "became the conduits through which the internationally sponsored family planning program sought to establish itself outside the realm of governmental control" (Asdar Ali 2003: 324). The process can divide NGOs, as larger, more established organizations receive funding and gain influence while smaller, grassroots groups, particularly those critical of government or donor policies, are marginalized.

Women's groups around the world are now well aware that health sector reforms are affecting women's access to health services, and that many policymakers are either unwilling or unable to integrate reproductive health services into national health systems. Yet, merely calling upon them to do so does not challenge the interests behind the reforms. Nor does it clarify the reasons why governments have less money for health care, why politicians believe free markets are the best way to provide health care, or that the reforms are linked with other global financial and trade processes, agreements, and interests.[10]

NEO-LIBERALISM'S IMPACTS ON HEALTH

Economic reforms have been to the detriment of women's health more generally, not just to the health services they need. Since women tend to be more economically disadvantaged than men, they also tend to suffer more from SAPs and the requirements of bilateral, regional, and international neo-liberal trade agreements, such as those of WTO. Together

they reduce poor women's access to food, clean water, sanitation, decent housing, livelihoods, quality education, and a healthy working and living environment. When neo-liberal economic policies are implemented, "the family, particularly women within it, acquire the role of shock absorbers in the absence of any other form of social security" (Qadeer 1998b: 37).

The result has been a rise in women's poverty and ill-health. A large proportion of maternal and infant deaths in India, for instance, is attributable not to a lack of contraception, or even to little or no access to quality health care services, but to undernutrition, anemia, and communicable diseases stemming from lack of food, poverty, and inequity. According to a 1995 WHO and World Bank analysis, 30 percent of women's and 12 percent of men's overall burden of disease and disability is related to reproductive ill-health. These rough estimates suggest that a large proportion of the health problems of women, men, and children are other than those relating to reproductive health (Koivusalo and Ollila 1997: 199). Diseases that are predominantly infectious cause some two-thirds of women's deaths in India. Data on women's mortality in India indicate that the largest proportion of female deaths occur before women have children; nearly 30 percent of female deaths are of girls under the age of 15. Of women of reproductive age, nearly 30 percent of deaths are caused by major infectious diseases (tuberculosis [TB], malaria, cholera, pneumonia, diarrhea, dysentery, and jaundice), while about 12.5 percent of deaths are due to childbirth and conditions associated with it. The proportion of women who are not pregnant and who die because of anemia is several times higher than the proportion of pregnant anemic women dying. It has been argued that, "given the overall health situation among women, dominated by communicable diseases, anemia and under-nutrition, to concentrate on reproductive health is to utterly miss the woods for the trees" (Rao 2004: 195).

Neither the POA nor its institutionalized concept of reproductive rights addressed the forces that were having such a negative impact upon the determinants of health, other than to endorse them. As with its health service recommendations, the Programme opted for the very neo-liberal market-oriented policies that had widened income, mortality, and morbidity gaps between and within countries in the first place. Although the POA defined "reproductive rights" as the right of women "to decide freely and responsibly the number, spacing, and timing of their children

and to have the information and means to do so", it did not explain how
a woman can:

> . . . avail herself of this right if she lacks the financial resources to pay for
> reproductive health services or the transport to get to them; if she is illiterate
> or given no information in a language she understands; if her workplace is
> contaminated with pollutants that have an adverse effect on pregnancy; or
> if she is harassed by parents, a husband or in-laws who will abuse or beat
> her if they find out she uses birth control. (Petchesky 2003: 18–19)

The Programme promoted women's rights and reproductive rights only
"within the context of the dominant neo-liberal agenda, which negatively
affects women's health and aspirations for empowerment" (Silliman
1999: 151). It failed "to address macroeconomic inequities and the in-
ability of prevailing neoliberal, market-oriented approaches to deliver
reproductive and sexual health for the vast majority". These fault lines
"continue to block any real progress in transforming the reproductive and
sexual health/rights agenda from noble rhetoric into actual policies and
services" (Petchesky 2003: 35–36).

Ironically, putting reproductive health and rights at the center of
population policies has encouraged policymakers to continue to think
of women only as wombs, to the neglect of their wider economic and
social roles, and of the conditions that could advance health for women.
Qadeer has argued that the ICPD "converted women's health into issues
of 'safe abortion' and 'reproductive rights'" and "marginalized the issue
of comprehensive primary health care, social security, and investment
in building infrastructure facilities" (Qadeer 1996).[11] Policymakers and
many international women's groups did not consider the inadequacy of
their isolated strategy in the context of the immensity of women's health
problems, the social constraints on women's lives, or indeed of women's
expressed needs for land rights, food, security systems, minimum wages,
and freedom from atrocities and communal peace (Qadeer 1998a: 21). But
when reproductive rights are divested of rights to food, employment, water,
and health care and taken out of the contexts of women's and men's lives,
and when children's lives are not secure, such rights "fit in well with the
neo-liberal agenda of the day" (Rao 2004: 196).[12]

What is needed instead is a framework firmly linking reproductive and
sexual health issues to both human rights and macroeconomic policies.

As was noted in the run up to the ICPD, but ignored in the POA itself: "reproductive health and justice . . . has to do with contraceptive services, with eradication of hunger, with education, with health, with income, with clean water, etc. All of which can be achieved only in a completely overhauled system" (Keysers 1994: 28–29).

BACKLASH AND FUNDAMENTALISMS[13]

One reason why many women's rights activists lobbying in the early 1990s for reproductive and sexual rights did not pay sufficient attention to the structural and macroeconomic conditions for those rights was because they were diverting "disproportionate energy towards combating . . . fundamentalist and traditionalist attacks" on women's rights. Yet the impacts of "economic fundamentalism", particularly the insecurities and exclusions created by neo-liberalism, have enabled religious or ethnic fundamentalist movements and groups:

> to gain more of a hold in both the North and South. In the South these forces feed on insecurities created by the loss of livelihoods in urban and rural areas evoking explicitly anti-women sentiments as a way to provide cultural identity . . . In the North, people's sense of economic insecurity and the loss of self in the mire of consumerism has led to a rise in fundamentalist right-wing groups that are sexist as well as racist and xenophobic. (Harcourt 2003: 4)

Corrêa argues that the growth and violence of fundamentalisms on the ground "are directly related to the outcomes of market-oriented globalization" (2003: 22). In global arenas such as official policy circles, meanwhile, their virulence "can be interpreted as a response to 'our agency'" (ibid.).

In what can be seen as a backlash against the Cairo framework and its human rights approach, the United Nations, in consultation with the IMF, World Bank, and Organization for Economic Co-operation and Development (OECD) (but not "civil society"), ignored the POA's goal of reproductive health services being accessible to all women who need them by the year 2015 when it drew up its eight Millennium Development Goals in September 2001 (Antrobus 2003: 68).[14] Even sections of the women's health movement that had supported feminist population policies expressed

disillusionment. As the journal *Reproductive Health Matters* commented, "Thus does 25 years of international work for women's health vanish into thin air not with a bang but a whimper" (Berer 2001: 6).

In the United States, meanwhile, President George W. Bush's first official presidential act in 2001 was to reimpose the "global gag rule". This prohibits any NGO overseas from receiving US government aid if it provides or makes referrals for abortions, actively promotes abortion, or lobbies for reform of its country's abortion laws.[15] Since 2002, the US administration has refused to pay its approved US\$34 million contribution to UNFPA. Development Alternatives with Women for a New Era (DAWN) contends that "since the Bush administration took over in the US, every negotiation (such as those at UN conferences on AIDS, children, and sustainable development) that relates to women's human rights has been the scene of enormous struggle" (DAWN 2003: 2).[16]

The Women's International Coalition for Economic Justice (WICEJ) links the attempted dismantling of the reproductive rights agenda to today's intertwined fundamentalisms—the fundamentalism of the market, and ethnic and religious fundamentalism (WICEJ 2003). Both can cause women to lose not only their livelihoods, economic security, and much of what remaining control they have over their lives and bodies. They are also "dismantling women's hard-won rights to define a sexual rights and reproductive health agenda, to express their sexual and reproductive rights, and to have access to resources that assure life choices leading to reproductive health and well-being" (Harcourt 2003: 36).

NEO-MALTHUSIAN THINKING

Neo-Malthusian or populationist thinking in population and development programs and institutions also restricts women's ability to exercise their reproductive and sexual rights. Such thinking views women's education, welfare, and programs of women's empowerment, in which contraceptive provision can be a part, not as ends in themselves but merely as a means to "getting the numbers down".

Progressive organizations, including many women's groups, have not challenged this thinking sufficiently; indeed, they frequently endorse it. Although the Programme of Action does not contain the phrase "population problem", identify demographic factors as the principal causes

of any problem, or seek many demographic changes, a neo-Malthusian subtext still runs through it. The Programme's ultimate goal is "population stabilization", and it regards women's empowerment and the elimination of "social, cultural, political and economic discrimination against women" mainly as prerequisites for the low fertility that this requires. Hodgson and Watkins conclude that the Programme presents "protecting the individual rights of women . . . as an indispensable means for achieving aggregate neo-Malthusian ends" (1997: 470).

It might seem to make little or no practical difference whether reproductive rights and health are a "means to an end" rather than an "end in themselves". Surely access to family planning or jobs or education under a population policy aimed at restricting fertility is better than no access at all?

But thinking of women's empowerment, education, or employment as a means rather than an end, as the Programme of Action and the World Bank do (the WTO ignores these issues altogether), has disturbing practical consequences. The history of contraceptive development and provision illustrates the point. Whether a contraceptive is provided within a reproductive health policy aimed at enhancing women's self-determination, or within a population policy designed to reduce women's fertility, makes a difference to the design of the contraceptive itself. Because the research and design of contraceptives has long been guided by the aim of reducing population growth rather than enhancing women's self-determination, "the lion's share of money for contraceptive research is spent on long-acting, provider-controlled surgical, hormonal and immunological methods which promise a bio-medical approach to fertility control" (Bandarage 1997: 80). One consequence is that the "goal of pregnancy prevention has taken precedence over safety in contraceptive research, leading to a lopsided emphasis on the 'more effective', or high-tech, methods" (Hartmann 1995: 38).

In contrast, methods such as the condom and diaphragm are under the user's control, help prevent the spread of sexually transmitted diseases and have no adverse impact on breastfeeding, but are "grossly neglected, both in terms of the allocation of research funds for their improvement and their promotion and distribution in population programs" (ibid.: 38).[17] The need to separate "the women's agenda of empowerment and self-determination from the population agenda of mass fertility control" is as important today as it was in the 1990s (Keysers 1994: 2).

Neo-Malthusian thinking also threatens women's reproductive and sexual rights when it acts through institutions that formulate and carry out economic, development, and immigration policies. The Programme of Action calls for population concerns to be incorporated "in all relevant national development strategies, plans, policies and actions". Thus, Western countries proclaim themselves "full up" and unable to admit migrants (even as the number of children being born there drops to below "replacement level") while at the same time pushing economic policies that make more and more people "surplus" to economic requirements. They support wars, development projects, and climate change that create ever-larger enforced migrations from the South (The Corner House 2003). Claims that burgeoning numbers of immigrants steal jobs, are parasites on state welfare, and destroy the environment derive in large part from Malthusian thinking; even though the word "population" itself may seldom be used.

The policies and actions that flow from such beliefs undermine the rights and interests of many more social groups than just women of child-bearing age. Immigrants, the elderly, the disabled, and those needing welfare have been added to the list of traditional population "targets", such as women, indigenous peoples, people of color, and Southern farmers. Neo-Malthusian thinking has not only bolstered public antagonism, racism, and fear in many places, feeding renewed calls for population control and harsh measures against migrants, but has also encouraged attacks on women's rights.

Those driving to create "free" markets today by privatizing, undermining or abolishing public health and social services, and emphasizing individual responsibility consistently derive strength from the goals of neo-Malthusianism. As Rachel Simon-Kumar points out:

> . . . although neo-Malthusian and neo-liberal discourses are distinct ideological-influences (the former emphasising fertility control and the latter economic rationalism), it may be argued that in the context of developing countries the two are intricately intertwined. In India, for instance, the ideology of economic growth is inseparable from an anti-natalist agenda. Neo-Malthusianism becomes a component of the neo-liberal economic ideology of the state. (2004)

Campaigning for reproductive and sexual rights within a neo-Malthusian framework is as fruitless as doing so within a neo-liberal program. Even if small gains are made along the way, the framework will inherently work against such rights. Demands for reproductive rights and social justice must be made outside of a population framework at the same time as the neo-Malthusian thinking underpinning so many health, welfare, employment, immigration, education, national security,[18] and privatization policies that impinge upon women's self-determination is itself challenged.

CONCLUSION

Groups seeking to implement reproductive and sexual rights have to confront macroeconomic, fundamentalist, and neo-Malthusian agendas that perpetuate gender, race, and class inequalities and impede the vast majority from achieving those rights. In the past decade, it has become much clearer that the struggle for reproductive health and rights is nothing less than the democratic transformation of societies to abolish gender, class, racial, and ethnic injustice (Corrêa and Petchesky 1994: 107). Many movements, groups, and individuals are already engaged in this struggle. As Betsy Hartmann concludes:

> While feminists may find some space within the [Cairo] consensus to negotiate for higher-quality contraceptive, abortion and health services and increased access to economic and educational resources, the real political space will remain outside, in an alliance with progressive development agencies, social justice environmentalists, and anti-racism organisers. In the New World Order not only are reproductive rights at stake, but basic economic survival and political freedoms. (1995: 155)

Defense of women's reproductive and sexual rights has been most successful not just where NGOs and governments are supportive but also where popular movements are strong, as in Brazil, the Philippines, India, and South Africa. To be effective, such movements need to build networks and alliances with each other. After all, peace, health, environment, women's, indigenous, anti-racist, and economic justice movements are confronting many of the same forces and interests that are ranged against

them. Moreover, activists working on issues of reproductive rights, migrant support, genetically-engineered agriculture, anti-racism, and disability rights (to name a few) are all affected by neo-Malthusian ideology and practice.

Feminist activists from different parts of the South and North have made their presence felt at international gatherings such as the World Social Forums in recent years. In doing so, they pave the way for reproductive and sexual rights to be incorporated within the larger agendas of other social movements and of society in general. Numerous encouraging initiatives at local and national levels give hope for new ways of making alliances and working for change.

Activists need to "rethink identity and alliances—combine a critical analysis of economic, political, cultural, and social models of the past with a forward-thinking vision of what a socially just future might look like" (Kelsey 1995: 372). The vision of women's health groups, anti-racist movements, disability rights groups, grassroots activists, and others can be not just of social justice but of "an alliance which can forge a new way ahead" (ibid.). Such an alliance can help link the single-point goals of many movements and causes to a broader politics of democratization.

NOTES

1. To stress the voluntary nature of the actions sought, and in contrast to the implied force associated with phrases such as "population control" or "population reduction", experts have begun to use terms such as "stemming", "stabilizing", or "slowing" population growth. See 'Journalist's Notebook: What's in a Word?', December 1998, quoted in Hartmann (2002: 259).
2. The IWHC was set up in 1980 when the Population Crisis Committee gave the US National Women's Health Coalition, reconstituted as the IWHC, a grant to promote menstrual regulation and early-term abortion in Southern countries. The Population Crisis Committee is a US pressure group lobbying for the US government to grant public funds for population control. It was set up in 1965 and changed its name to Population Action International in the 1990s. The IWHC's funding sources shifted from the Population Crisis Committee to the Hewlett, Mellon, Ford, and MacArthur Foundations (Hodgson and Watkins 1997: 497).
3. The Declaration did not challenge the need for population policies, but called "for a fundamental revision in [their] design, structure and implementation . . . to foster the empowerment and well-being of all women" (Antrobus et al. Unpublished manuscript).

4. Mainstream US groups active in such marginalization, perhaps "blinded by the bright lights of power", tended to focus their attention overseas, ignoring the increasing violence, reproductive rights violations, and withdrawal of welfare to which poorer women of color, in particular in the US, were subject. As Hartmann has noted, "especially for white middle-class groups, it is much easier to sound progressive on the international stage than to do the hard work of multiracial network building at home" (Bhattacharjee 2001; Hartmann 2002: 4).

5. Since official international population assistance began in the mid-1960s, the United States has been the acknowledged leader in the field. It has consistently been the largest donor, has provided much of the intellectual leadership linking fertility reduction with economic development, and has been the pillar of multilateral efforts through the UN system, the World Bank, and organizations such as the International Planned Parenthood Federation (IPPF). The US Agency for International Development (USAID) established an office of population in 1964, began funding direct family planning activities in 1967, and has continuously emphasized the role of the private sector and social marketing in population programs.

6. In the 1980s, population organizations had also developed close strategic alliances with mainstream environmental organizations. "Population was a convenient . . . way to divert attention from the lack of strong activism against industrial polluters". The alliance benefited population groups more than environmental ones as the former have not taken on a broader environmental agenda. This environmental alliance, combined with the alliance between population groups and women's groups, not only "lets Northern governments and elites (and Southern ones too) off the hook for environmental degradation", but also casts them as gender-sensitive conservationists and family planners (Hartmann 2003).

7. More generally, some have argued that women's organizing for the Cairo process not only blunted the critical analysis of the global women's health movement, but also helped to "depoliticize" it and concentrate power in the hands of a few well-funded, mainly US-based organizations (Hartmann 2003: 4; Swenson 2000).

8. For an analysis of the difficulties in turning health care into profitable marketable commodities, and summary of the evidence and experience that health care services are inherently not private goods, see Mackintosh (2003).

9. Hilary Standing suggests three reasons why "sexual and reproductive health was almost invisible" in the health sector reform agenda. First, a language and discourse gap between the two agendas: one used a managerial/technocratic language, the other an advocacy language. Their supporters rarely interacted internationally, nationally, or locally. Second, health sector reform has focused on supply side interventions such as financing mechanisms and human resources management; sexual and reproductive health advocacy has been concerned with service delivery. Third, health sector reformers regarded sexual and reproductive health services as vertical or "special interest" programs, which they neglected other than to make them more efficient financially. Sexual and reproductive health advocates did not understand the importance of engaging with reforms (Standing 2000: 10–19).

10. For a case study description of this process in Tanzania, see Richey (2003a, 2004: 923–40).

11. From a different perspective, British sociologist Frank Furedi contends that promoting population policies through the rhetoric of women's health has become central to "the marketing of fertility control". This medicalization of population issues "is seldom contested, because it appears to be entirely about the non-controversial subject of health". One result of describing population policies in terms of reproductive health has been that the "underlying agenda of fertility control becomes inconspicuous to the designated target audience" (Furedi 1995: 139).

12. Another result of neo-liberal economic policies is the privatization and lack of regulation of family planning services themselves, as corporations, non-governmental organizations, and philanthropic bodies become more involved (Rao 2004).

13. "Fundamentalism" is a broad term not limited to any one religious grouping or referring to an individual's religious observance. Contemporary fundamentalisms are political movements occurring all over the world that tend to use religious language and symbols in an attempt to win or consolidate power and extend social control. They appear in different and changing forms, sometimes as a state project, sometimes in opposition to the state. Central to their agendas is support for patriarchal forms of family and authority through which to control women in various ways. They often view women as embodying the morals and traditional values of the family and the community. Their adherence to "doctrinaire patriarchialism" ties together diverse fundamentalist adherents, whether Christian, Islamic, Jewish, Hindu, or other. For more information, see Women Against Fundamentalism, www.waf.gn.apc.org.

14. The Millennium Development Goals (MDGs), however, do specify discrete targets for and indicators of maternal health, child mortality, contraceptive prevalence, and HIV/AIDS, malaria, and other major diseases. The health, education, and poverty eradication goals identified are narrowly defined and disconnected from each other and wider contexts, but easily measurable and quantifiable. "Gender equality" is identified as a discrete goal, rather than attention being paid to the gender dimensions of other goals such as poverty eradication and combating HIV/AIDS (Antrobus 2003: 6–8).

15. The rule was first signed by President Ronald Reagan in 1984 after the UN's International Conference on Population in Mexico City, but suspended by President Bill Clinton almost a decade later. An estimated 20 million women have abortions each year in countries where abortion is restricted or prohibited by law. Because unsafe abortion accounts for an estimated 13 percent or more of maternal mortality globally, many policymakers and activists regard access to safe and legal abortion as a fundamental safeguard for women's health, even if they do not think of it as a right. Abortion was made illegal in many countries only in the 19th century.

16. Comments Fatou Sow, "The current Bush administration can be considered fundamentalist because of its alliance with right wing fundamentalist groups in the US, and a very conservative and fundamentalist approach to the values of family, sexual and reproductive health and rights" (DAWN 2003: 37).

17. In the past decade, HIV/AIDS has increased the interest in some quarters into researching and providing barrier contraceptive methods. Nonetheless, reproductive rights

and health analyst Lisa Richey argues that the primary focus of current international population policy on the countries of sub-Saharan Africa that have high fertility rates and the concomitant emphasis on contraceptive delivery is undermining efforts to address AIDS in Africa (Richey 2001, cited in Hartmann 2003: 13).

In Tanzania, AIDS and reproductive health programs are still thought of, and implemented through separate channels to the detriment of both.

> A population discourse dominated by concern for controlling fertility, whether by women, couples or governments, precludes adequate incorporation of the challenges that AIDS brings to health care policy . . . When HIV/AIDS is at the centre of women's lives—even though it is unspoken—and reproductive health services do not involved meaningful interventions for prevention and treatment, AIDS threatens to render meaningless the other important accomplishments of the reproductive health agenda. In the midst of the AIDS pandemic in many African communities, "reproductive health" might be best understood as being able to remain healthy long enough to reproduce and raise children . . . AIDS challenges us not just to expand the scope of the old population policies with interventions for tackling the disease, but to rethink the justifications for these policies, their primary actors and their goals. (Richey 2003b: 30–35)

18. National security issues are increasingly invoked to support Cairo's Programme of Action. For instance, a 2003 report from Population Action International suggests that civil conflict is generated in large part by demographic factors, even though conflict has invariably diverted resources away from women's access to food, clean water, sanitation, and health care, and led to the spread of disease and thus undermined women's reproductive health and rights significantly. The prevalent nexus of neo-liberalism, fundamentalism, and militarism, moreover, threatens women's health and rights still further. This nexus builds on arguments developed in the 1990s linking conflict with demographic factors and environmental degradation (Cincotta et al. 2003; Rehn and Johnson Sirleaf 2002). For a critique of these arguments, see Hendrixson (2004).

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3

Liberal Ends, Illiberal Means: National Security, "Environmental Conflict", and the Making of the Cairo Consensus*

BETSY HARTMANN

INTRODUCTION

The 1994 United Nations International Conference on Population and Development (ICPD) in Cairo was widely heralded as a victory for women's reproductive rights over both coercive population control programs and conservative religious fundamentalists that are opposed to contraception and abortion. While the ICPD's embrace of women's reproductive health and empowerment was a welcome and a long overdue reform of population policy, the Plan of Action agreed on in Cairo, essentially, left intact deeply problematic neo-Malthusian understandings of population growth as a principal drain on social, economic, and environmental resources. Today, as the fundamentalist backlash against Cairo intensifies, aided and abetted by the Bush administration in the United States, there is a tendency to remember only the positive aspects of Cairo and to forget the negative. In the process, important lessons of that complex historical moment are easily lost, lessons which have continuing relevance today.

This chapter looks at the role of neo-Malthusian ideas, actors, and interests in the formation of the Cairo consensus, focusing on those associated with US foreign policy and more specifically, the environmental conflict field. In the mid-1990s, the idea of environmental conflict enjoyed considerable popularity in US foreign policy circles. Its principal architect was Canadian political scientist, Thomas Homer-Dixon. He argued that scarcities of renewable resources such as cropland, fresh water, and forests, induced in large part by population pressure, contribute to migration and violent intrastate conflict in many parts of the developing world. This conflict, in turn, can potentially disrupt international security as states fragment or become more authoritarian:

> Fragmenting countries will be the source of large out-migrations, and they will be unable to effectively negotiate or implement international agreements on security, trade and environmental protection. Authoritarian regimes may be inclined to launch attacks against other countries to divert popular attention from internal stresses. The social impacts of environmental scarcity therefore deserve concerted attention from security scholars. (Homer-Dixon 1994: 40)

Homer-Dixon was first propelled into public view in 1993 when he co-authored an article on "Environmental Change and Violent Conflict" in *Scientific American* (Homer-Dixon et al. 1993). A year later, Robert Kaplan's (in)famous article "The Coming Anarchy" popularized and sensationalized Homer-Dixon's ideas. Proclaiming the environment as the most important national security issue of the 21st century, Kaplan presented West Africa as a nightmare vision of things to come: a hopeless scene of overpopulation, squalor, environmental degradation, and violence, where young men are post-modern barbarians and children with swollen bellies swarm like ants (Kaplan 1994).

"The Coming Anarchy" seized the imagination of the liberal foreign policy establishment, including Vice President Al Gore and President Bill Clinton. "I was so gripped by many things that were in that article," Clinton remarked in a speech on population, ". . . and by the more academic treatment of the same subject by Professor Homer-Dixon. . . . You have to say, if you look at the numbers, you must reduce the rate of population growth" (State Department 1994).

A number of factors converged to make environmental conflict an idea whose time had come (Dalby 2002). The end of the Cold War was forcing

a redefinition of security, while environmental problems, ranging from nuclear contamination to soil degradation, were added to the panoply of potential threats. Monitoring the environment also provided defense and intelligence agencies with a new rationale for the maintenance of expensive satellite and underwater surveillance systems (Deibert 1996).

While environmental conflict fitted comfortably into the evolving field of environment and security, it interacted with other policy concerns as well. With the end of Cold War clientism, a series of "state failures" in the Third World, notably in Africa, posed new challenges to the US foreign policy establishment. In particular, the disastrous US intervention in Somalia highlighted the need for a more anticipatory strategy of preventive defense, addressing the roots of political conflict before it exploded into all-out civil war. Homer-Dixon's model of environmental conflict provided the kind of causal reasoning policymakers were looking for. By emphasizing the role of migration in fomenting conflict, the model also meshed well with growing anti-immigrant sentiment in Washington, D.C.

However, no understanding of the impact of the environmental conflict field would be complete without a consideration of the role of the ICPD. Not only did Homer-Dixon's model of environmental conflict draw heavily on neo-Malthusian assumptions about the relationship between population and the environment, but his work was also supported by private population-oriented foundations and promoted by senior government officials in preparations for the ICPD.

This chapter is based primarily on Ph.D. research undertaken between 1998–2002, which included interviews with approximately 70 people in government and multilateral agencies, research and policy institutes, foundations, universities, and non-governmental organizations (NGOs) in the US and Europe (Hartmann 2003).[1] I chose whom to interview on the basis of their known involvement and/or interest in population and environmental conflict concerns. In September 2002, Thomas F. Homer-Dixon generously allowed me to spend several days going through his extensive computer and print archives at the University of Toronto, which proved invaluable to understanding the evolution and impact of his three major projects. Geoffrey D. Dabelko, Director of the Woodrow Wilson Center's Environmental Change and Security Project (ECSP), also helpfully opened ECSP files to me in 1999.

The chapter first takes a critical look at a key neo-Malthusian assumption in environmental conflict theory, what I call the "degradation

narrative"—the belief that population pressures and poverty precipitate environmental degradation, migration, and violent conflict. It goes on to examine the actors and interests in the Clinton administration and private population lobby that promoted Homer-Dixon's work as part of a strategy to broaden national security and garner support for the ICPD. It focuses especially on the role of private foundations in the production of knowledge. It concludes by looking at the tensions this strategy generated between those willing to use demographic fears of the Third World in the pursuit of liberal foreign policy goals and feminists in the population field who thought it undermined the ICPD's agenda of women's empowerment and reproductive health. This tension still exists today as certain population agencies link demographic dynamics to terrorism in a strategic bid to sustain international family planning assistance in a hostile conservative political climate.

PEASANT DESTROYERS

Over the last four decades, population control has been a remarkably stable feature of US foreign policy toward the Third World. Fear of overpopulation has also shaped, and continues to shape, the worldview and environmental consciousness of many Americans. Indeed, neo-Malthusianism has an almost religious power in the United States. It may lack a church, but it has numerous well-funded institutional organs, both private and public, to practice and spread the faith not only domestically, but around the world. On a conceptual level, it has developed a canon which is strict enough to resist challenges, but malleable enough to adapt to new constituencies and issues. It has also generated negative images, tropes, and narratives—a reservoir of core stereotypes—which resonate deeply in the psyches of its believers.[2] If God is not on its side, Nature surely is. Eve is black, primitive, and pregnant, and her reproduction is the Original Sin.

Of concern in this chapter is the particular role of neo-Malthusian "degradation narratives"[3] in shaping Western views of the relationship between population, poverty, and environmental degradation in the Third World. More recently, environmental conflict theorists such as Thomas Homer-Dixon have extended the causal chain to include migration and

violent conflict. Vaclav Smil humorously describes the resulting equation: "eroding slopelands = environmental refugees = overcrowded cities = political instability = violence" (1997: 108).

The widespread belief that poor peasants are responsible for most land degradation in the Third World has roots in the colonial era when colonial administrators often blamed peasant agricultural practices and population pressure for soil erosion, deforestation, and desertification. In areas of settler agriculture in eastern and southern Africa, for example, land expropriation policies "demanded both the creation of a conceptualization of the African peasant as 'backward' and 'inefficient', and the privileging of environmental knowledge based on Western experience" (MacKenzie 1995: 102; see also Rocheleau et al. 1995).[4]

This image of not only a backward, but also a destructive peasantry, is carried over into the post-World War II development thinking. The notion of a singular, ahistorical peasantry itself is part of a larger process which Escobar terms "discursive homogenization", in which the poor are constituted as universal subjects, with little regard for differences outside of certain vague client categories such as malnourished, small farmers, landless laborers, etc. (Escobar 1995: 53). Meanwhile, "discourses of hunger and rural development mediate and organize the constitution of the peasantry as producers or as elements to be displaced in the order of things" (ibid.: 107). Within large development agencies like the World Bank, degradation narratives came to serve as a rationale for problematic agricultural modernization programs and population control interventions (Williams 1995).

Degradation narratives have persisted despite important challenges from within the development field. In 1987, Blaikie and Brookfield's book *Land Degradation and Society* offered a systematic analysis of the causes of land degradation across regions and time periods, challenging the common hypothesis that population pressure on resources was chiefly to blame (Blaikie and Brookfield 1987). Instead, the authors called for a regional political ecology approach that would address the complexity and specificity of land use practices, focusing in particular on the social and economic constraints faced by "land managers" (See Appendix to this chapter for a further critique of the degradation narrative).

While critical literature such as this had an impact on the development field, it had little influence on the emerging concept of sustainable

development in the late 1980s. The roots of sustainable development were not in development theory, but rather in Northern environmentalism with its quite limited understanding of Third World political economy and ecology (Adams 1995). Liberal sustainable development advocates were more willing to acknowledge the role of social and economic disparities, such as unequal land distribution in the creation of rural poverty, so on first inspection their analyzes appeared more sympathetic to the poor. As their argument proceeded, however, these inequalities faded from view. The poor made themselves even poorer by having too many children, setting in motion a vicious downward spiral of increasing poverty and environmental degradation (Harrison 1992).

In the mid-1980s, sustainable development incorporated the vague notion of "environmental refugees" into its lexicon, expanding the degradation narrative in the process. The displacement and movement of marginalized people form the main link between the degradation narrative and (in)security concerns: their migration to other rural areas incites ethnic tensions; their young unemployed sons gravitate to political extremism in already overcrowded cities; and when they cross international borders, they threaten national social and cultural cohesion.[5]

Our Common Future, the influential 1987 report of the UN World Commission on Environment and Development (commonly known as the "Brundtland Report"), elevated the degradation narrative to the status of received wisdom and drew a close connection to violence. The report identified poverty as a major cause of environmental degradation:

> Those who are poor and hungry will often destroy their immediate environment in order to survive. They will cut down forests; their livestock will overgraze grasslands; they will overuse marginal land; and in growing numbers they will crowd into congested cities. (World Commission on Environment and Development 1987: 28)

Although the report distinguishes nuclear war as the gravest danger to the environment and security, it identifies environmental stress as an important source of conflict, noting in particular the destabilizing effects of "environmental refugees". It advocates the use of the most sophisticated surveillance technology to establish an early warning system to monitor indicators of environmental risk and conflict, such as "soil erosion, growth in regional migration, and uses of commons that

are approaching the thresholds of sustainability" (World Commission on Environment and Development 1987: 302). In this sense, it presages more recent developments in environmental surveillance and securitization (Hartmann 2003).

Concerns about environmentally-induced conflict accelerated with the end of the Cold War, and came to dominate the rethinking of security that occurred in the early 1990s. "Of the new sources of conflict, the combination of environmental and demographic pressures have received the most attention", states a Rockefeller Brothers Fund review of the North American literature on the new security thinking (Florini and Simmons 1998: 20). Homer-Dixon, in turn, was the leading theorist of the emerging environmental conflict field.

Homer-Dixon claims that he is not a neo-Malthusian in the sense that he does not accept that "finite natural resources place strict limits on the growth of human population and consumption". He has pointed out how technological and institutional change can boost productivity and induce environmental improvements (Homer-Dixon 1999: 28). Despite these disclaimers, population growth is the single largest causal factor of environmental scarcity in both his project's model and case studies, and his concept of "ecological marginalization" is essentially a recasting of the degradation narrative (Homer-Dixon and Blitt 1998).[6] Homer-Dixon blames population growth disproportionately for environmental degradation, poverty, migration, and ultimately political instability. Around the planet, he claims:

> Population growth and unequal access to good land force huge numbers of rural people onto marginal lands. There, they cause environmental damage and become chronically poor. Eventually, they may be the source of persistent upheaval, or they may migrate yet again, helping to stimulate ethnic conflicts or urban unrest elsewhere. (Homer-Dixon 1999: 155)

Timura (2001) argues that environmental conflict is a boundary object whose vagueness has allowed a wide variety of actors and institutions, including military and intelligence agencies, to appropriate it to serve their own interests. One could also argue that the degradation narrative served as a sort of boundary object within a boundary object, and that its prominence in Homer-Dixon's work, as well as the way his model gave it a new respectability and legitimacy, attracted the attention and support of population actors and interests. This is the subject of the next section.

POPULATION, PHILANTHROPY, AND FOREIGN POLICY

Strategic Philanthropy and "Ideological Conversion"

In the United States, private foundations form a major link in the chain joining corporate, academic, public policy, and government interests. In certain fields, such as population, they have served as the key catalyst in the creation of both an academic discipline and a public policy response. Dowie (2001) divided the history of American foundations in the last century into three main periods: the first, prior to World War II, focused on the advancement of formal knowledge, especially in the hard sciences; the second, post-World War II, involved the foundations more directly in the formation of public policy in what is sometimes called "strategic philanthropy" (Lagemann 1999); and the third, starting in the 1960s, saw the foundations take a more proactive role in promoting their visions of social justice. These divides, of course, are somewhat arbitrary and certain patterns are common to all three.

In the second period, growing philanthropic interest in public policy reflected profound changes in the political environment in the US. In the wake of both the New Deal and World War II, public policy-making became a much more intentional and calculated effort across a wide variety of institutions, both at home and abroad (Prewitt 2001). In the case of population, private funding was initially focused on building an academic demographic establishment closely linked to policy-making. Historians of US demography have noted how as a result, the field often sacrificed scholarly rigor to the needs of its paymasters, ultimately playing the role of "handmaiden in family planning programs" (Demeny 1988: 10).[7]

In the 1950s, the Rockefeller and Ford Foundations became actively involved in promoting population control as an integral part of US foreign policy. Their most enduring legacy was the successful creation of an international academic and policy elite invested in fertility reduction as a national development strategy. One does not have to be a conspiracy theorist to recognize the way this network of experts was intentionally created. Foundation money spawned the establishment of population centers at major US universities; these existed in a semi-autonomous relationship with more traditional academic departments such as sociology. Foreign students were brought to the centers where they were persuaded of the urgent need to reduce birth rates in a process the Caldwells refer to as "ideological conversion" (Caldwell and Caldwell 1986: 140).

While the centers' independent stature within the university permitted demographers to blend academic and applied research, their relative isolation reduced the possibility of contact with other scholars and intellectual developments in the social sciences. For example, most demographers were not exposed to critiques of modernization theory in the late 1960s and 1970s (Greenhalgh 1996). There is an interesting parallel here with the relative isolation of many security scholars in the US, including Homer-Dixon, from current debates in the development field.

Foundations also sponsored a number of reports on population which were distributed free of charge to policymakers. Often written in subdued scholarly language, they nevertheless conveyed a sense of crisis about population growth (Sharpless 1997). Such reports were not sufficient, however, to build the kind of broad popular consensus necessary to sustain massive and long-term US investment in population control in the Third World. According to Wilmoth and Ball (1992), that depended on the coverage of population issues by popular magazines, newspapers, and other forms of media. Their study of the population debate in American popular magazines from 1946 to 1990 highlights the remarkable rise in articles about the "threatening" aspects of population growth, which peaked in the mid-1960s. Framing the issue in environmental terms proved the most effective in terms of building a popular consensus for population control. In a sort of informal feedback loop, demographers at the foundation-funded population centers served as important sources for these neo-Malthusian articles (Caldwell and Caldwell 1986).

The close linkages between private foundations, academic population centers, policymakers, and the popular press helped reinforce and spread neo-Malthusian ideas throughout the body politic until ultimately population control became an important tool of US foreign policy. By 1967, the USAID was providing US$35 million annually in international population assistance (Donaldson 1990). However, even with increased government support of population control, private foundations remained active in the field.

FORGING THE CAIRO CONSENSUS

In the 1980s, resistance to US population policies began to mount from two separate but powerful quarters. The first was the anti-abortion

movement that found favor in the Reagan administration. At the 1984 UN population conference in Mexico City, the administration announced the implementation of the first "gag rule", the denial of US funds to any private organization which performed or even just counseled women about abortion. Meanwhile, a growing transnational alliance of feminist reproductive rights and health activists began to organize against coercive population control policies, calling instead for reproductive health programs that respected women's needs for safe, voluntary birth control, and abortion services (Corrêa 1994; Hartmann 1995).

Concerned about the growing strength of anti-abortion forces and facing feminist pressure from both outside and within, many population agencies made the strategic decision to ally with transnational women's health activists in advance of the 1994 ICPD in Cairo (Hodgson and Watkins 1997). The result is what is called the "Cairo consensus". This consensus maintains that rapid population growth is still a major cause of poverty and environmental degradation, but that women's empowerment and reproductive health programs are the solution to high birth rates, instead of the top-down, target-driven, and often coercive, population programs of the past.[8] Private philanthropic funding was instrumental in forging this consensus in conjunction with the US State Department, especially the office of Under-Secretary of State for Global Affairs, Timothy Wirth.

One of the most important foundations involved in building the Cairo consensus was the Pew Charitable Trusts, a relative newcomer to the population scene. Pew, whose wealth derives from the Sun Oil Company, came to the population issue primarily through its interest in the environment. By the early 1990s, it had become the largest environmental donor in the US and as well as one of the most proactive. In a classic example of Dowie's third phase of proactive philanthropy, Pew set out to reshape the agenda of the American environmental movement; its tame lobbying strategy, muted criticism of corporate practices, and sometimes domineering style drew the ire of many activists in the field (Dowie 2001; Greene 1994; Tokar 1997). An important component of Pew's proactivity was the funding of public relations and media campaigns (Bailey 1994).

Expanding its mandate, Pew began to look more closely at foreign policy issues related to the environment. In 1993, the foundation established the Pew Global Stewardship Initiative (PGSI) to address population and consumption issues in preparation for the ICPD. PGSI was a

collaborative effort with the Aspen Institute, a high-powered policy think-tank based in Colorado but with offices in Washington, DC. Susan Sechler was hired to be PGSI director. Sechler is known as a dynamic philanthropic and policy entrepreneur. During the PGSI project, her base at the Aspen Institute in Washington gave her a fair degree of independence, though it led to an uneasy relationship with the Pew leadership in Philadelphia (Hartmann 2003).

The creation of PGSI was part of a larger liberal strategy of "stewardship" which Sechler and others in the foreign policy arena were pursuing at the time. According to this reasoning, the US has a triple responsibility as the world's premier superpower. It must not only maintain its military and economic strength, but exercise stewardship through foreign aid, NGOs, and the private sector to address potentially destablilizing problems in the Third World, such as resource scarcities and widening gaps between rich and poor. While acknowledging that Cold War strategies of containment "sometimes" were at variance with social stewardship objectives, advocates believed that those contradictions no longer existed in the post-Cold War period (Mazur and Sechler 1998: 20).

Stewardship is a win-win approach, in which free market capitalism, democracy, and US hegemony are instrumental to human development and environmental improvement. It is based on a sense of the superiority of American values and the belief that they are the universal aspirations of mankind (Gore 1993: 270). While such American universalism may be preferable to conservation isolationism, it has a dark side too. "For such universalism to take root", Stoett notes, "the image of a frightening outside world must first be created" (Stoett 1999: 19). As Sechler herself told me, "People will get more aid if they are perceived to be dangerous than if they are pitied" (personal interview, November 13, 2000).

PGSI's July 1993 White Paper laid out four major project objectives: *(a)* "to build a stronger conceptual base for global stewardship and its expression in enlightened population and consumption policies"; *(b)* "to forge consensus among diverse constituencies' working on these issues, as well as to attract new ones"; *(c)* "to inform and improve relevant US and multilateral policies and programs"; and *(d)* "to increase public understanding of, and commitment to act on, population and consumption challenges" (PGSI 1993a: i). These goals would be accomplished by collaborating with institutions and individuals from three major constituencies:

environmentalists, religious communities, and international affairs and foreign policy specialists.

In regard to the latter, Pew hoped to broaden the concept of national security in ways that invoked Homer-Dixon. The White Paper stated:

> The Initiative will endeavor to assist foreign policy specialists in framing the related concerns of population, environment and sustainable development, and in identifying areas where demographic trends threaten regional or international stability. The goal is to elevate these concerns in US foreign policy formulation, international agreements and the work of multilateral institutions. (PGSI 1993a: 13)

To develop the conceptual base for this endeavor, PGSI would offer support for applied research on the linkages between population, environment, and security.

While its applied research strategy was more academic in tone, PGSI also aimed to influence the media and popular opinion. It hired three top American polling and opinion research firms, representing both Democratic and Republican interests, to do a focus group research on attitudes toward population growth and the environment among different constituencies. Interestingly, the researchers found that most people did not have strong neo-Malthusian attitudes; they recommended adding "an emotional component" and "targeted visual devices", such as pictures of traffic jams and degraded landscapes, to promotional materials and advertisements on population in order to create the necessary alarm (PGSI 1993b: 73–74).

PGSI also hired the Future Strategies Inc. consulting firm to make recommendations on how to build a campaign on population and sustainable development in Washington policy circles (PGSI 1994a). Although it is unclear whether PGSI followed all the consultants' advice, the report provides a fascinating window on the reasoning behind the strategic use of demographic alarmism. The Future Strategies report highlights the need for a "grand strategy" to increase international family planning and women's health assistance. The strategy would entail promoting this assistance as critical to environmental protection, as well as to the alleviation of the causes of violent conflict (ibid.: 4–5). An information database on population and environment would be an important advocacy tool since "though the link between excessive population and environmental destruction would seem obvious, there is . . . little in the way of

scientific evidence to draw exact correlations" (PGSI 1994a.: 11). The report rues the fact that despite PGSI funding, the US environmental groups remain "behind the political curve" on developing programs linking population and environmental degradation (ibid.: 2).

Americans will have to be convinced that "unchecked population growth and destruction of the environment are key national security concerns of the 21st century" (ibid.: 31). So will specific constituencies, such as defense and intelligence policymakers and intellectuals as well as Congressional actors, notably the Black Caucus who should be worried about the social chaos in Africa described by Robert Kaplan (ibid.: 20).

The report considers a variety of arguments to sway the public and policymakers, including concerns about migration. For example, "One clear payoff is reducing the immigration pressure which will only increase if poverty and resource depletion go unchecked." The report notes that, "these sorts of arguments can be made without reinforcing racist and isolationist strains in the American political culture" (ibid.: 33). Further on, the authors write that, "Unfortunately, the specter of 'environmental refugees' driven by scarcity of resources and flooding American borders may be necessary to build the public support necessary for required increases in funding for population and sustainable development" (ibid.: 35). Along with such arguments, it recommends using visual tools such as computerized mapping which overlays information about "population growth, resource depletion, overt conflict and refugee movements" (ibid.: 13), as well as adopting some of the campaign tools of the American Israel Political Action Committee (ibid.: 33).

The PGSI leadership was not blind to the contradictions inherent in using fear and alarmism to build support for liberal foreign policy goals, but its pragmatic pluralism overrode moral qualms. Looking back on the period, Susan Sechler told me that she was looking for ways of bringing people under the tent who could contribute to the project. She also wanted to include people who would be destructive if they remained on the outside. Although she does not believe in fear-mongering per se, she thought it was better

> to voice fear and deal with it, deal with the unconscious, put the stuff out on the table . . . If you don't think about the dark side, it will come out. You can't keep people from thinking about these things.

People are afraid of chaos, she noted, and though critical of Kaplan now, she said his writing was a "wake-up call", and was at least preferable to talking about throw-weights (the weight of the payload of a missile) (personal interview, November 13, 2000).

Sechler was also interested in creating a more open foreign policy, where Americans' own aspirations for themselves and their children were linked to the aspirations of people in other countries. US foreign policy suffers from the belief that it can be done in secret, she remarked, that policymakers can "just work with the leaders and treat the Third World as a ghetto where you help organize markets and police forces . . . the more people who can relate to the Third World and democracy (with a small 'd'), the more pressure on Congress and the Senate" (personal interview with Susan Sechler, November 13, 2000).

Sechler's broad-tent approach was reflected in many aspects of PGSI's work and proved instrumental in shaping the Cairo consensus. Despite the caveats of feminist friends who warned of the Malthusian "environmental juggernaut" (personal interview with Sechler, November 13, 2000), she funded the population work of mainstream environmental organizations in the hopes that they would come around to a women's agenda. She was also the primary founder of the Woodrow Wilson Center's Environmental Change and Security Project (ECSP), which became the epicenter of the environmental security field, a venue where scholars and policymakers could interface directly with each other.

To involve the security community further, she brought Homer-Dixon into the tent, funding two out of three of his major projects. Initiated in 1994, Homer-Dixon's Environment, Population and Security (EPS) project received a PGSI grant of US$300,000, which included US$30,000 for Robert Kaplan as a project consultant. That same year the Environmental Scarcities, State Capacity and Civil Violence Project received US$200,000 from PGSI, and Sechler was instrumental in leveraging the other US$200,000 in funding from the Rockefeller Foundation Population Sciences Program. Rockefeller viewed the project as an outlier in its population portfolio which was focused more directly on family planning research and policy (Hartmann 2003).

The EPS project, initially known as "Fast Track", was the one most directly geared toward policymakers. According to the initial work plan, the project's aim was "to produce a large volume of material as quickly as

possible for use in current policy debates" (EPS 1994a: 1). Indeed, "the value to policy makers of the anticipated product" was one of the three criteria used to determine the focus of research efforts (ibid.: 3). Along with country and thematic case studies, a briefing book on environmental security issues for policymakers and members of the media was part of the work plan. Project publications were sent out by to a list of over 1,000 policymakers, representatives of the media, scholars, and so on.

Homer-Dixon was a logical choice for PGSI's strategy of targeting policymakers, for he had already arrived with a splash on the Washington scene. Kaplan's "The Coming Anarchy" had brought him to the attention of top policymakers, including Al Gore (Pugliese 1994), who invited him for dinner in April 1994 and to do a briefing on China in August of the same year. Like Homer-Dixon's, Gore's environmentalism was heavily tinged with neo-Malthusianism (Gore 1993). So was the environmentalism of Under-Secretary of State for Global Affairs Timothy Wirth, who, for example, blamed the massacres in Rwanda and political unrest in Haiti on demographic pressures (Wirth 1995).

Formerly a senator from Colorado and a close political colleague of Gore's, Wirth was appointed Under-Secretary of State for Global Affairs as part of the Clinton administration's reorganization of the State Department. In the follow-up to the 1992 Earth Summit, Wirth had as many as 150 people working under him in the State Department, although throughout his tenure he operated below the level of a senior policymaker (Hopgood 1998). Almost everyone I interviewed, who had been in Washington during the period, acknowledged that Wirth played a central role in organizing US participation in the ICPD, particularly the NGO coalition. Although when he first joined the State Department he had little knowledge of women's health concerns, he was able "to make the reproductive rights link" with population and environment issues.

Wirth was influenced by Kaplan and Homer-Dixon's work. His own beliefs were "neck on neck" with Homer-Dixon's, whom he promoted in policy-making circles around the ICPD. The affinity was not only ideological but strategic. According to one of his close associates, one reason Wirth seized on the environment and security issue was because its appeal to the security community allowed him to involve them in promoting the ICPD. Whether or not it actually influenced policy was not as important as the way it got different players to the table to promote the Cairo consensus,

including the CIA which became part of an inter-agency working group. Environment and security was a tool to pique people's interest and get them to the right advocacy goal, such as women's rights (personal interview with Ellen Marshall, June 10, 1999).

PGSI employed a similar strategy, using Homer-Dixon's EPS project to build bridges to the security community. It put together a high-level stewardship and security steering committee which met to advise Homer-Dixon in the fall of 1994 (PGSI 1994b). Among its members were Eileen Claussen, Senior Director for Global Environmental Affairs on the National Security Council, Kathleen McGinty, Director of the White House Office on Environmental Quality, and Enid Schoettle, National Intelligence Officer for Global and Multilateral Issues and a principal advisor to the Director of the CIA.[9] That Homer-Dixon had access to such high-level officials suggests both PGSI's clout within the foreign policy establishment and the weight given to Homer-Dixon's project within PGSI.

While Homer-Dixon's model of environmental conflict helped bring the national security community into the ICPD coalition, it also elevated the degradation narrative into the high politics, or at least rhetoric, of national security. According to Dabelko and Simmons (1997), late in 1993, following a briefing by Homer-Dixon, the National Security Council Global Environmental Affairs Directorate and the office of the Deputy Under Secretary of Defense for Environmental Security "began to incorporate environment and conflict ideas into their work" (p. 135). In 1994 and 1995, the administration's *National Security Strategy of Engagement and Enlargement*, which is considered an important blueprint for foreign and defense policy, stated boldly in the preface that "Large-scale environmental degradation, exacerbated by rapid population growth, threatens to undermine political stability in many countries and regions" (White House 1995: 47).

Certainly, from about 1994 through 1997, some mention of environmentally induced conflict seems *de rigueur* in official speeches and reports on the environment, whether emanating from the administration, State Department, intelligence community, or the Defense Department. Even if he is not mentioned by name, Homer-Dixon's ideas, often couched in language very similar to his, are very much present. For example, in 1994 Eileen Claussen, recently appointed NSC Senior Director for Global Environmental Affairs, delivered a speech, which drew heavily on Homer-Dixon's notion of environmental scarcity. "Lack of access to productive

agricultural lands combines with population growth to encourage mi-
gration to steep hillsides", she stated. "These hillsides are easily eroded,
and after a few years fail to produce enough to support the migrants.
The result is deepened poverty which then helps to fuel violence." Like
Homer-Dixon, she went on to link resource scarcities to the insurgencies
of the New People's Army in the Philippines and Sendero Luminoso in
Peru (Claussen 1995: 40–41; Homer-Dixon 1999).

In 1996, Director of Central Intelligence John Deutch linked satellite
surveillance directly to the degradation narrative and the threat of
environmentally-induced conflict:

> Environmental degradation, encroaching deserts, erosion and over-farming
> destroy vast tracts of arable land. This forces people from their homes
> and creates tensions between ethnic and political groups as competition
> for scarce resources increases. There is an essential connection between
> environmental degradation, population growth, and poverty that regional
> analysts must take into account.

> National reconnaissance systems that track the movement of tanks through
> the desert, can, at the same time, track the movement of the desert itself, see
> the sand closing in on formerly productive fields or hillsides laid bare by
> deforestation and erosion. Satellite systems allow us to quickly assess the
> magnitude and severity of damage. Adding this environmental dimension
> to alert policymakers to traditional political, economic, and military analysis
> enhances our ability to alert policymakers to potential instability, conflict
> or human disaster and to identify situations which may draw in American
> involvement. (DCI Speech 1996: 1)

Such concerns about the potential for environmental conflict were also
an important factor behind Gore's move to establish the CIA's Envir-
onmental Center to serve as a focal point for environmental issues within
the intelligence community.

The mid-1990s, then, were marked by a certain ideological confusion
as women's rights, neo-Malthusianism, environmental conflict, and dark
Kaplanesque visions of the Third World were woven together into the
fabric of liberal American stewardship. There was a certain method to
the madness, however, as PGSI's strategies reveal. Not everyone in the
population field was sanguine about these developments. Section III
considers internal divisions within the population community about
whether or not to use the threat of environmental conflict as a rationale
for supporting the Cairo reforms.

DO THE ENDS JUSTIFY THE MEANS?

When I began my research, I assumed that because population funding was instrumental in the development and promotion of the environmental conflict field, population organizations were likely to jump on the proverbial bandwagon. I found, however, that the reality was more complex. While there were a number of public and private population agencies that purposefully tapped into environmental conflict discourse, other actors in the field were more wary, worrying that the national security angle might undermine the Cairo reforms and the coalition that brought them about.

As one representative of a prominent population NGO told me, at first environment and security looked like it was going to be a big deal, but it didn't have much sticking power because it was problematic. "What alliances would we make if we used it?" the representative said. "How would it affect our relationship with women's groups and environmental groups? If there are alliances to be made with conservative groups, what values does one place at risk? The population community does look for common ground with conservatives in Congress, but only if the core values of Cairo are not compromised." Nevertheless, this same person was considering doing a publication on environment and security if it would be useful in getting policymakers to see the importance of family planning.

Indeed, a number of population agencies did use environmental conflict for this purpose. Population Action International featured Homer-Dixon's ideas in its 1997 publication *Why Population Matters*, designed to make the demographic case for family planning assistance (Engelman 1997). A 1999 issue of *Population Reports* on "Why Family Planning Matters?" published by the USAID-funded Population Information Program at Johns Hopkins University, contains a section on resource conflicts that draws directly on Homer-Dixon (Population Information Program 1999).

The RAND Corporation's *Population Matters* series did a report in 2000 on *The Security Dynamics of Demographic Factors*, again drawing on Homer-Dixon's work, financed by the US Army and major population funders, the Hewlett-Packard, and Rockefeller foundations. This publication links the need for more US family planning assistance to governments "that wish to take the direct approach of reducing their fertility rates outright" to the army's need for technologies such as unmanned aerial surveillance vehicles and better body armor to fight in overcrowded urban areas of the Third World (Nichiporuk 2000: 51–52). A full-page

advertisement in the *New York Times* (June 19, 2002: A15) by the Population Institute attributed resource depletion, environmental degradation and civil unrest (as well as hunger and grinding poverty) to poor women's unintended pregnancies.

The two population projects which tapped most heavily into environmental conflict ideas were the Population Reference Bureau's (PRB) joint project with the Center for Strategic and International Studies (CSIS) in Washington, DC on *Population and National Interests* (CSIS 1996) and the Rockefeller Foundation's lobbying publication *High Stakes* (Rockefeller Foundation 1997). The PRB/CSIS publication presents family planning as preventive diplomacy to mitigate a whole host of threats posed by population pressure, including conflict caused by resource scarcity. It emphasizes the connection between resource scarcity and migration, especially from Haiti,[10] and asserts that the US must regain control over its borders. PGSI instigated the collaboration between the two agencies; PRB was supposed to influence CSIS, but the context remained very much a security one. This led to a certain amount of disenchantment on the part of the PRB.

One of the PRB participants, Alex de Sherbinin, told me it was difficult to get the security people involved to move beyond the concept of the national interest to embrace development issues. The development people, meanwhile, were "twisting and turning" to relate to the security people but lost something in the process (telephone interview with Alex de Sherbinin, June 29, 1998). He ended up writing a critical article challenging the conventional environmental conflict line on Haiti (de Sherbinin 1996).

The controversy surrounding the Rockefeller Foundation's *High Stakes* report reveals the sharp division within the population community on whether or not to use environmental conflict arguments. Designed to counter international family planning budget cuts by a conservative Congress, the report draws heavily on Homer-Dixon to argue that unless steps are taken to reduce "surging population growth", resource scarcities will "ignite simmering tensions" and foment violent upheavals around the world (Rockefeller Foundation 1997: 21). A foundation officer justified this line of argumentation to me on the basis that even if 10 percent of the report was alarmist, the other 90 percent was about reproductive health, and the only way to reach conservatives in Congress was through the idea of enlightened self-interest. The report was released with great fanfare in

Washington. According to a prominent reproductive health advocate, the mythology at Rockefeller was that it really turned the tide in Congress, though in reality it was "in the dirt lobbying" that saved international family planning assistance.

The process of drafting the report produced an ideological struggle in the population community. According to Joan Dunlop, who was then President of the International Women's Health Coalition, the draft was heavily criticized by reproductive health advocates, including herself. A line was clearly drawn between those willing to use national security arguments in the service of population assistance, and those who thought they would undermine the Cairo reforms.

Sometimes agencies experienced internal divisions about whether or not to highlight the threat of environmental conflict. USAID is a case in point. There was, and continues to be, a tension between those at the agency who view the population issue within a reproductive rights/ reproductive health perspective and those who see population growth as a key "strategic threat" that "consumes all other economic gains, drives environmental damage, exacerbates poverty, and impedes democratic governance" (USAID 1993: 7), and thus demands a strong results-driven family planning response. After the 1994 ICPD this division became even more pronounced at the Population, Health and Nutrition Office (PHN) at USAID. In my interviews I was told by several people at USAID that reproductive health now had the upper hand in PHN and that environmental security ideas were not very popular.

However, there were notable exceptions to this trend. Brian Atwood, USAID Director at the time, borrowed heavily from Kaplan and Homer-Dixon in painting horrific visions of a degraded, violent, and overpopulated Third World.[11] More importantly, Joanne Grossi, then Senior Technical Adviser and Head of USAID's Population and Environment Initiative, began to fund the Woodrow Wilson Center's influential Environmental Change and Security Project (ECSP) when Pew funds dried up in 1997. Grossi stepped in as PGSI's Susan Sechler stepped out. (Today, the ECSP also receives funding from an additional population-oriented foundation, the David and Lucile Packard Foundation.) The financial support of population interests helped ensure that environmental conflict, with its emphasis on the degradation narrative, remained a dominant theme of the

ECSP. In the early years, especially Homer-Dixon's work is a major point of reference, and today population issues still occupy pride of place in the annual *Environmental Change and Security Project Report.*

When I interviewed Grossi in 1999, PHN's contribution to the ECSP had risen from US\$75,000 to US\$600,000. She explained that the symmetry was beneficial; while USAID money helped the ECSP improve its reputation and attract more government officials to its events, the ECSP helped USAID get more of an audience for population issues. She did not foresee any concrete policy changes emerging from the collaboration, but instead more in the way of "intangibles" like the chance to dialog. She remarked that some people at USAID hoped that having the Department of Defense (DOD), CIA, Congressional staffers, and so on, in the same room at the Wilson Center would help them to see USAID differently and impact how Congress feels about the agency. In terms of environmental security, the ECSP "was one of the only games in town" (personal interview with Joanne Grossi, June 9, 1999).

The eight years of George Bush Jr.'s administration were, of course, a very different political moment than the 1990s in respect to population policy, concern for the environment, and national security. Strongly allied with religious fundamentalist and anti-abortion forces, the Bush administration was hostile to international family planning assistance and the Cairo reforms which advocate sexual and reproductive rights. Indeed, many in the population field worried that "Cairo was dead" due both to conservative opposition and the concentration of foreign aid resources on HIV/AIDS. Environmental concerns were also hardly on the top of the Bush administration's to-do list; instead environmental regulation was the target of much undoing. September 11 and the "war on terror", meanwhile, resuscitated Realist views of national security and US hegemony. The 1990s era of "rethinking security" seems a very long time ago.

It is not surprising that under siege, population interests would find it tempting once again to resort to national security arguments to win support from legislators, policymakers, and the public for international family planning assistance. A worrying indication of this trend was a recent report from Population Action International, *The Security Demographic: Population and Civil Conflict after the Cold War* (Cincotta et al. 2003). Released with great fanfare at the Woodrow Wilson Center, under the

auspices of the ECSP,[12] the report purports to prove that four demographic stress factors—*(a)* the youth bulge (a high proportion of young males in a given population);[13] *(b)* rapid urban growth; *(c)* competition for cropland and freshwater (with echoes of the degradation narrative and Homer-Dixon); and *(d)* AIDS-related deaths in the prime of life—contribute to a heightened risk of civil conflict in the developing world. The report confuses statistical correlation with causation and reinforces negative stereotypes of the dark and violent poor. On its cover is an ominous picture of a young black man carrying a gun, with a crowd of what looks like protestors behind him.

The report's end goal is to prove that reducing population growth will help reduce violent conflict. And the best way to reduce population growth is through women's empowerment and reproductive health, in other words the Cairo approach. The report thus once again marries the Cairo reforms to national security threats and fears. Its release rated a Reuters story "Study: Women's Health Linked to Unrest: High Birth Rates, AIDS Set Stage for Global Violence" (Reuters News Service 2003), and news of it circulated, uncritically, on various progressive websites, including that of *Common Dreams* (Lobe 2003).

What is wrong with using such a strategy if it works to get the attention of policymakers to women's rights? Don't the ends justify the means?

Bad means, however, have a way of undermining good ends. Using the security argument to advocate for reproductive health is always a danger, a prominent feminist in the population field told me. Perhaps if human security had really replaced conventional security in the 1990s, it might be all right, but it didn't and the bogeyman from the 1950s persisted. "You can't 'take back the night' on security," she concluded (phone interview with Judith Bruce, Population Council, October 17, 2002).

What are some of the dangers of using a security rationale? On the most basic level, viewing women as breeders of conflict is likely to have a negative effect on how family planning services are delivered, encouraging a reversion back to target-based population control, despite any rhetoric to the contrary. You can't have your cake and eat it too. Good quality reproductive health services depend on viewing women's rights as worthy of pursuit in and of themselves, not as a neo-Malthusian instrument of national defense. And then there is the issue of ideological obfuscation.

Is it really demographic and environmental stress that is causing most of the conflict in the world today? Blaming the Third World poor is one of the oldest games in town. It draws on and reinforces racism both at home and abroad, and does nothing to illuminate deeper causes of conflict or possible solutions.

The Obama administration in Washington might provide an opening, but it might equally well—with the assistance of strategic philanthropy— renew the lease neo-Malthusianism holds on political life and foreign policy in the United States. Indeed, the population lobby in Washington is once again intensifying its efforts to make population control a centerpiece of US foreign policy. The primary strategy is to blame global warming and political conflict on overpopulation. Some hardliners are even calling for the abandonment of Cairo and the reproductive rights rationale for family planning. In the process they are alienating many feminists working in the international reproductive health field. Whether the population lobby succeeds or fails will depend to a large extent on the degree of feminist resistance. The lessons of the 1990s should be remembered. This chapter is offered as a cautionary tale.

APPENDIX

CHALLENGING THE DEGRADATION NARRATIVE

The following are some of the key problems with degradation narratives:

Overgeneralization: Degradation narratives ignore the great diversity in both social systems and ecological conditions in the Global South. Context, contingency, agency, and specificity are sacrificed to a universalizing "one size fits all" model.

Localization of blame: In focusing on poor peasants and pastoralists as the destroyers of the environment, degradation narratives do not take into account other social, economic, and political forces which may be strongly implicated. "Effective demand" from elsewhere for a region's natural resources may drive environmental degradation much more than local poverty or population growth. For example, the crucial role of extractive industries—mining, timber, agribusiness, and so on—does not figure in the story at all. Also ignored are the complex interactions between resource appropriation and power structures at the local, regional, national, and international levels (Fairhead 2001).

Neo-Malthusian causality: The belief that population pressure is *automatically* associated with both increased poverty and environmental degradation is overly simplistic and deterministic. Whether or not population pressure is beneficial or damaging to the environment depends on a host of intervening institutional and technological factors as well as the nature of the particular environment in question.

Degradation narratives fail to take into account that under some circumstances, population pressure may spur agricultural innovation and intensification. For example, while population growth may decrease the size of landholdings, it can also expand the family labor supply, encouraging more labor-intensive cultivation and conservation techniques. Thus, a study in Rwanda found that declining land-holdings were associated with more investments in soil conservation and greater managed tree densities per unit of land (Templeton and Scherr 1999). Degradation narratives also ignore the possibility that *depopulation* of an area may lead to environmental decline. In Brazil, for example, many areas depopulated by poor peasants because of their lack of access to land and agricultural inputs have gone over to ecologically damaging extensive cattle raising, industrial monoculture, and logging. Similarly, in Mexico, the exodus of poor peasants to urban areas has led to the loss of valuable micro-habitats and crop genetic diversity previously sustained by their labor (Garcia-Barrios and Garcia-Barrios 1990; Mello 1997).

Such is the power of neo-Malthusian reasoning, however, that in some studies, such as a 1999 UNEP report on Africa, increases in population density are used as a proxy for the location of emerging environmental threats (Singh et al. 1999).

Failure to consider livelihood diversification: Degradation narratives tend to pro-mote a one-dimensional view of the peasantry as living solely off the land, ignoring the reality that many peasant households have diversified livelihood strategies. In a village in Bangladesh, for example, one family may have different members engaged in agricultural labor, petty trade, rickshaw driving, teaching, and service in the military. Income derived from non-agricultural activities, meanwhile, is often invested back in productivity-increasing land improvements (Hartmann and Boyce 1983).

Degradation narratives also fail to differentiate types of rural poverty and their relationship to environmental change. Agrarian scholars have pointed out how poverty cannot be treated as a single concept and that assets must be broken down into specific categories. When households are "investment poor", lacking the cash and human resources to invest in maintenance or enhancement of the natural resource base, then environmental degradation is more likely to occur. However, there are many different reasons for investment poverty, and analyses need to be

time and site specific. Moreover, the precise nature of the environmental change in question must be specified (Reardon and Vosti 1995).

Migration: Degradation narratives have a similar one-dimensional view of migration as distress-generated and generating. However, the causes of migration are extremely complex and context-specific, and there is little evidence to support the view that demographic pressure is at the root of many population movements (Suhrke 1997). Moreover, migration from rural areas is often not a linear phenomenon or a rejection of rural livelihoods. Instead, it can be a vital part of sustaining them. A study in Vietnam found that internal migration is frequently circular and seasonal, with migrants returning to the rural areas at harvest time. Their remittances from urban jobs often help fund investments in agricultural intensification, children's education, and so on, enhancing the ecological and social resilience of the household (Locke et al. 2000).

Gender: Despite lack of explicit attention to gender issues, certain views of women are implicit in degradation narratives, especially given the central and negative role they ascribe to population growth. Subsumed into the analytic frame of population pressure, women through their fertility become the breeders of environmental destruction, poverty, and violence, and controlling their fertility becomes the magic bullet solution. Women's access to land and property rights, labor obligations, roles in environmental resource management, and relative status in the household and community are not part of the picture, even though gender dynamics can have an important impact on agriculture and the environment. Case studies in Africa note how in many places women are making the day-to-day decisions about agriculture when access to land is still invested in men, a contradiction which can lead to agricultural stagnation (Turner et al. 1993).

NOTES

1. See Hartmann (2003) for a full list of interviewees.
2. See Karim (1997) for a discussion of the role of such core stereotypes (*topoi*) in the representation of the Third World "Other".
3. Recent scholarship points to the important role environmental narratives play in policy formation and outcome. See, for example, Harper (2001); Keeley and Scoones (2003); Roe (1995), and on environmental conflict specifically, Timura (2001).
4. The extent of degradation was often overstated not only due to value bias, but also faulty scientific methodologies. The exclusion of historical data on landscapes led to speculative projections about the past which romanticized previous environmental conditions, or conditions at a particular time were assumed to be representative of an abiding state

of affairs. For example, colonial administrators viewed the low population densities found in East African savannahs at the beginning of the 20th century as the norm, but in reality they were the result of a severe depopulation of humans and livestock as the result of recent war, famine, and disease (Leach and Mearns 1996). See Leach and Fairhead (2000) for a more recent example of faulty methodologies.

5. For a critique of the concept of "environmental refugees", see Black (1998). Without any substantive evidence, Norman Myers claimed that there were 25 million environmental refugees in the world, who could also be termed "population pressure" refugees (Myers 1995: 63).

6. Other environmental conflict theorists have similarly embraced the degradation narrative. See Baechler (1999); Kahl (1998), and Lietzmann and Vest (1999).

7. Other important references on this subject are Hodgson (1983, 1988, 1991); Szreter (1993); and Greenhalgh (1996).

8. See Hartmann (2002) for an analysis of the pros and cons of the Cairo consensus.

9. Other members were Judith Bruce of the Population Council; Stephen Del Rosso of the Pew Charitable Trusts; John R. Dellenback, a Presbyterian Church leader; David Devlin-Foltz of PGSI, demographer Leobardo Estrada; PGSI Program Officer Susan Gibbs; political scientist Jack Goldstone; Robert Kaplan; Paul Kennedy; Robert Litwak of the Woodrow Wilson International Center for Scholars; Christopher Makins of the Aspen Institute; Georgetown University Professor Theodore Moran; George Perkovich of the W. Alton Jones Foundation; Jeremy Rosner of the Carnegie Endowment for International Peace; Emma Rothschild; Susan Sechler; John Steinbruner of the Brookings Institution; Michael Teitelbaum; Barbara Torrey of the National Research Council; Thomas Wander from American Association for the Advancement of Science (AAAS); and Jeff Wise at the Aspen Institute's Environmental Security Policy Project (PGSI 1994c). Interestingly, Homer-Dixon had recommended to Sechler in June that Joan Dunlop of the International Women's Health Coalition be part of the advisory team since she could help the project understand how its findings might be received or misperceived by women's groups. However, Dunlop did not join the team, and the project ended up having little contact with women's groups.

10. At the time, CSIS was doing a major study of population and security in Haiti. See CSIS (1996).

11. In one speech, Atwood said, "If rural migrants overwhelm the cities by the tens of millions, we must breathe the air they pollute and drink the water they foul. Their diseases will find us. Their misery will envelop us" (Atwood 1996: 86). Also see Atwood (1994).

12. The Wilson Center event on December 17, 2003 featured commentary by retired defense and intelligence officials, and an introduction by William H. Draper III, the son of Major General William H. Draper, Jr, whose official study of the US military assistance program in the late 1950s made the argument that population control should be an important matter of national security (Ross 1998).

13. See Hendrixson (2002, 2004) for a critique of youth bulge theory, and Hartmann and Hendrixson (2005) for the way the youth bulge and degradation narrative are both implicated in today's strategic philanthropy.

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4

The Politics of Abortion: A Note*

MARLENE FRIED

INTRODUCTION

US President Barack Obama's first executive act on January 23, 2009 was to rescind the "global gag rule". This rule prohibits US government aid from going to any organization or institution that provides or makes referrals for the medical termination of pregnancy; otherwise actively promotes abortion; or lobbies for reform of its country's abortion laws. The rule was first signed by President Ronald Reagan in 1984 after the UN's population conference in Mexico, suspended by President Bill Clinton almost a decade later, and then reimposed by President George W. Bush in 2001 as *his* first official presidential act.

In February 2009, however, the state legislature of North Dakota passed the first "Personhood Bill", which states that, as far as the constitution and laws of North Dakota are concerned, an individual, person, or human being "includes any organism with the genome of homo sapiens". What this Bill does in effect is to grant "personhood" rights from the moment a human egg is fertilized. Similar bills have been introduced (but as of mid-2009 not passed) in four other US states. While the Supreme Court's 1973 decision in the *Roe vs. Wade* case—a decision upon which legal abortion rights in the US have depended ever since, based on the right to privacy—acknowledged that the "fetus" is fully human, it did not grant any rights of "persons" until birth.

Taken together, Obama's suspension of the global gag rule and the North Dakota Personhood Bill indicate that the abortion issue and its

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politics continue to dominate reproductive and sexual politics in the US and thus continue to shape policies governing women's health and rights, not just within the US, but also worldwide.

While feminists have argued that access to safe abortion is both a fundamental human right and central to women's health, as we shall see, this is not the main reason why the abortion issue predominates. Rather it is because the political right in the US has made opposition to abortion—as indeed of gay and lesbian rights—the centerpiece of a broad conservative agenda. Threats to abortion access—legal, illegal, and sometimes violent—have been persistent. There have been highly visible attacks: in the US at least seven people involved in abortion case have been murdered since 1994, and over 80 percent of clinics which offer reproductive health services have experienced violence, threats, and serious harassment. There has also been a steady barrage of less dramatic attacks—restrictive legislation, lawsuits, and governmental policies—which have significantly eroded abortion access.

Abortion is not the only target of anti-choice activities. In effect, the entire "mosaic of reproductive rights and services" is under siege (Joffe 2005). Among the other casualties are access to contraception, sexuality education that includes anything other than abstinence, and health care for the 9 million women of childbearing age without access to contraception. This chapter focuses on abortion politics in the US, currently and historically, as well as their international impact. I will explain the nature of the threats from the Right and why women's rights' advocates in the US feel an urgency about abortion politics that President Obama's election has not entirely dampened.

In addition to the attacks from the anti-abortion movement, I will also critique other pro-choice politics. Within the reproductive rights movement, there has been frustration over the mainstream pro-choice movement's singular focus on abortion, and its use of the framework of individual choice. The inadequacy of "choice", the failure to disassociate abortion politics from population control, and the reduction of reproductive rights to abortion have divided feminists for decades. However, there have been important developments within the reproductive rights movement in the US in recent years. Women of color are rejuvenating the meaning and practice of reproductive rights with expansive understandings of reproductive freedom and multi-issue agendas for action. This provides an opportunity to create new alliances internationally and to join the abortion rights struggle to other health and social justice movements.

In exploring these issues, my perspective is informed by almost 30 years as an abortion rights activist and by co-authoring the book, *Undivided Rights: Women of Color Organize for Reproductive Justice*, which profiles eight organizations organized by and for women of color (Silliman et al. 2004). While I am critical of pro-choice politics, I am also unwaveringly committed to the importance of fighting for abortion rights as part of a broader struggle for women's ability to control their lives. As I will suggest, this position is captured by the concept of reproductive justice, which is being promoted by women of color organizations in the US.

ABORTION ACCESS WORLDWIDE

Where abortion is illegal or inaccessible, the search for abortion humiliates women and undermines their self-respect and dignity. Such abortions may result in criminalization, infertility, or death (Hlatshwayo and Klugman 2001: x).

In fact, unsafe and illegal abortion remains a major public health problem as well as a fundamental women's human rights issue. Worldwide, there are an estimated 46 million abortions each year (WHO 2003: 10). Induced abortion is one of the most commonly performed medical interventions. When legal and performed by trained providers, it is also one of the safest medical procedures. Despite this, the mortality and complication rates from unsafe abortion remain high because of restrictive laws and regulations, and inadequate and inaccessible services.

Women have abortions in every country, and at about the same rate, regardless of the law and no matter what their morality or religion dictates. There is no correlation between legal status and abortion rates. For example, in Latin America where abortion is highly restricted the rates are higher than in Western Europe where the procedure is legal everywhere, except Ireland (Allan Guttmacher Institute [AGI] 1999a: 3). The legal status is, however, crucial to women's health (AGI 1999b: 2). Annually, nearly 20 million abortions worldwide are unsafe, leading to an estimated 69,000 deaths annually, about 13 percent of all pregnancy-related deaths (WHO 2007). In countries where abortion is not legal, the complication rate is hundreds of times higher, and fewer than half of the

women experiencing serious complications receive hospital treatment (AGI 1999b: 32).[1]

Globally, nearly half of the abortions performed each year are unsafe, while one in four women in the world, most of them in developing countries, are governed by laws that ban abortion or permit it only to save a woman's life (ibid.). Unsafe abortion remains one of the main causes of maternal mortality (WHO 2003: 82). In most countries, women with economic resources can obtain abortions, while poor women are more likely to lack access, even when abortion is legal. It is primarily poor women who resort to unsafe abortions and suffer health consequences and/or death.[2]

While making abortion legal is necessary to ensure its safety, liberalizing legislation is not in itself sufficient to guarantee that all women have access to safe and legal abortion. For example, in India where abortion has been legal since 1971, many women still undergo illegal abortions because of inadequate or unaffordable services, and a lack of knowledge about legal abortion (AGI 1999b: 32). Access is a problem in Western countries too. In the United States, abortion was legalized in 1973, but many women lack access because of restrictive legislation which especially burdens poor and young women, an inability to pay, the uneven geographic concentration of services, and a shortage of providers (Boonstra and Sonfield 2000; Towey et al. 2005). Throughout the world, the most vulnerable women in a society are the ones who are the most harmed by the lack of access to safe, legal abortion.

In addition to changing laws, ensuring abortion access for all women requires closing the gap between legality and access; it also requires widespread societal and institutional change. To make this clear, the Johannesburg Initiative,[3] a project aimed at increasing advocacy for abortion access, defined the concept of "full access", articulating the range of conditions that have to be addressed if all women are to be able to obtain abortion care. This definition highlights the need for major improvements in health systems, information, education, and communication, and in providing training and ensuring sensitivity to the issue. The way that abortion is viewed in society at large must also be addressed. The anti-abortion forces are well aware of this. Their actions are aimed both at preventing women from having abortions and at molding public opinion, thereby stigmatizing abortion and women who have them.

RESTRICTING REPRODUCTIVE AND
SEXUAL RIGHTS: THE BUSH AGENDA

Although abortion was rarely mentioned by any of the candidates during the 2000 presidential election in the US, it was at the forefront of George W. Bush's agenda from the moment he took office in 2001. His appointments to high-level cabinet and agency positions, and nominations for federal judgeships included people who opposed abortion and contraception, and who had drawn opposition from civil rights and other social justice advocates. In addition to doing what he could through appointees, budget appropriations, and executive orders, Bush assured opponents of abortion that he would continue to sign all the restrictive laws that Congress passed. His track record speaks for itself. He signed the abortion ban, which President Clinton had vetoed, and which had already been declared unconstitutional by the Supreme Court. The fact that it was enjoined by three federal courts did not deter him. What was most important was that he showed himself to be faithful to an anti-abortion agenda and to the Christian fundamentalists that had been so crucial to his re-election in 2004. In his most dramatic gesture to them (in March 2005), President Bush interrupted his vacation to return to Washington, DC and sign national legislation intended to keep alive Terri Schiavo, a woman in Florida who had been in a coma for 15 years and whose feeding tube had just been removed.[4] The anti-abortion movement played a pivotal role in this case, mobilizing its constituents to hold vigils, commit civil disobedience, and pressuring Congress to pass the law. While these efforts did not prevail in the face of a judiciary that stood its ground, the case illustrates the strength of the anti-abortion movement, and the reach of abortion politics outside of the realm of reproduction.

The re-election of George W. Bush in 2004 further emboldened opponents of abortion, sexuality education, and gay/lesbian/bi-sexual/transgender rights. Despite the closeness of the election results, Bush was quick to declare that he had a mandate on everything from escalating the war in Iraq, to abstinence-only sexuality education and continuing to erode abortion access. Indeed, with the second Bush victory, opponents of abortion even hoped that the federal constitutional right to abortion would be rescinded,[5] leaving each individual state in the US to enact its own laws on abortion. The Center for Reproductive Rights has estimated

that, if this had happened, 30 states would have criminalized abortion and 20 would have legalized it, although the restrictions would have varied (Center for Reproductive Rights 2004).[6]

The groundwork for the Bush agenda was built up ever since abortion was legalized in the US in 1973. Anti-abortion politics got its first major boost in the 1980s when the presidency of Ronald Reagan moved the conservative Right, which had been on the margins of US politics, to a central position of power. The Right made opposition to abortion the focal point of its anti-woman and anti-sexuality agenda, which it has aggressively pursued since then. The long-range goal of the anti-abortion movement is to eradicate abortion rights entirely, but in the short run, their strategy has been to erode access. This is only part of a much broader effort to reverse the gains made by the women's, civil rights', and welfare rights' movements of the 1960s and 1970s.

As a result of their efforts, abortion and other reproductive rights have been seriously compromised, especially for the most vulnerable women in the US and throughout the world—those who are poor and young, with women of color everywhere bearing a disproportionate burden. Internationally, the global gag rule undermined services and the health of millions of people worldwide. Originally adopted by US President Ronald Reagan as the Mexico City Policy, it was rescinded by President Bill Clinton, and reinstated by President George W. Bush on January 22, 2001 until President Barack Obama rescinded it once again in January 2009. The rule prohibits foreign NGOs, which receive funding from USAID and/or the Department of State[7] regarding family planning measures, from addressing abortion, either through advocacy, referrals, or provision of services. NGOs that refused to comply lost the funds they used to get to run health clinics and provide other sexual and reproductive health services such as contraception and HIV/STI (Sexually Transmitted Infections) education.

In another damaging move, the Bush administration diverted 34 million dollars from UNFPA toward abstinence-only sexuality education programs in the US. Dr Pablo Rodriguez's description of the impact on women in Latin America can be generalized: " . . . the vote to restrict funding for international family planning represented a death sentence for thousands who found themselves without contraceptives and facing the uncertainties of unsafe abortion practices" (Rodriguez 2000: 10).

The Bush administration pushed its anti-abortion agenda at every international meeting on women's rights and health. At a session of the UN Commission on the Status of Women in March 2005, held to review the 1995 Fourth World Conference on Women, the US delegation tried to amend the Beijing Platform to exclude abortion and to "clarify" that the document does not create any new international human rights. After the amendment was opposed by more than 150 NGOs, the US withdrew it, claiming that it was not backing down, only that it was unnecessary. It took the same stance at the first regional meeting reviewing the ICPD. In Bangkok, in 1998, the US refused to reaffirm the importance of progress on women's health and rights. "The US delegation dominated negotiations with an agenda that ignored the health needs of women and girls over the objections of every other country present" (IWHC 2000).

IDEOLOGY, RELIGION, AND POLITICS PREVAIL IN SCIENCE

Abortion politics is also part of a long-standing battle over the separation between Church and State. Religious conservatives are continually looking for opportunities to blur the line between the two. Just a few years back, a judge in Arkansas refused to remove the Ten Commandments from his courtroom, and became a hero of the religious Right when he lost his job for this stance. Organizing against the teaching of evolution is another example. After a textbook on evolution became a standard part of secular curricula in the 1960s, well-funded, anti-evolution groups were created and have remained active for decades. After over 40 years, they have made important gains in education and in public opinion. In a November 2004 Gallup survey, only a third of US Americans believe that Darwin's theory is well supported by scientific evidence (Dizikes 2005: 1).

Under the Bush administration, religious groups not only played a greater role in politics; they also received substantial funding from the federal government. For example, Bush's Faith Based Initiative gives federal monies to religious groups who provide social services, but are not subjected to the same scrutiny or standards of accountability that non-religious providers are. There is also an increasing intrusion of religion and ideology into science itself, which is more covert. In some cases, this has

occurred by simply ignoring the advice of scientific advisory committees. A 2003 effort to allow emergency contraception (the morning-after pill) to be sold without a doctor's prescription was an example of this approach.[8] An advisory committee to the Food and Drug Administration (FDA) (which authorizes and regulates all pharmaceutical medicines) was overwhelmingly in favor of this move; the FDA would usually follow such an expert recommendation, but in this case they ignored it and prohibited over-the-counter sale.[9] Challenging accepted scientific knowledge, using pseudo or "junk science"—science which breaks all the rules of science in order to pursue a political agenda—has been another strategy increasingly used by the Right.[10] For example, the Centers for Disease Control (CDC) web pages no longer provided information on the proper usage of condoms, but mention only condom failure. Similarly, the CDC and the National Cancer Institutes were pressured to remove information about studies showing that the claim that abortion triggered breast cancer was unfounded. Only widespread public outcry led to the restoration of the information.

The aggressive promotion of "abstinence-only until marriage" and opposition to comprehensive sexuality education combines various approaches, including attacking evidenced-based science. Thus the standard for measuring the effectiveness of sex education programs was changed from looking at outcomes in sexual activity and pregnancy to counting attendance at sessions. At a time when there were major cuts in government funding for social support services, there were huge increases in spending for these programs—US$165 million appropriated for the 2005 budget. In such programs, all discussions of contraception were censored except to mention the failure rate of condoms. There is no credible proof that such programs are effective. Even worse, by limiting information and urging young people not to use condoms, they are dangerous. A 2004 report, based on a review of the most commonly used abstinence-only curricula, found that 11 out of 13 contain "unproved claims, subjective conclusions or outright falsehoods regarding reproductive health, gender traits and when life begins . . . " (House of Representatives 2004: 1).[11]

The consequences of these policies are felt not only in the US but also throughout the world. Over one-third of the funds for the Global Aids Initiative are earmarked for abstinence-only education. Funding for comprehensive prevention efforts has been reduced. When asked about how

he justified this spending in the absence of credible proof of effective-ness, the Secretary of Health and Human Services, who was also the chair of the Global Fund to Fight AIDS, Tuberculosis and Malaria, stated: "Let's try them out and see if we can't get it to work" (Rothchild 2004: 2).

FEMINIST FAULT LINES

While there is no question about the need to oppose the religious Right's reproductive and sexual health agenda, in contrast to what has seemed to be remarkable unity of those opposing reproductive freedom, there are deep divisions among feminists both about which attacks to resist, and how best to do so. There has also been an ongoing disagreement about the overall political framework within which abortion rights are supported. The ever-present threats from the anti-abortion forces make it difficult even to discuss certain issues out of fear of providing ammunition to the opposition. Failure to address them, however, weakens the feminist movement and undermines the possibility of effective resistance. In this section I will look at the major fault lines that have divided the reproductive rights movement: *(a)* the intersection of abortion politics with population control; and *(b)* framing abortion as choice. I will then propose an alternative vision of reproductive rights which encompasses the right to have children and the breadth of societal change required to enable all women to control their reproductive and sexual lives.

POPULATION CONTROL[12] AND ABORTION POLITICS

Women have often been denied access to safe contraception, sterilization, and abortion by patriarchal and religious forces, and have been forced to resort to clandestine and life-threatening procedures in order to control their own reproduction. At the same time, women in Third World coun-tries, as well as poor women, women of color, and women with disabilities in developed countries face efforts to prevent them from having children. Governments and financial institutions in the US and Europe have linked aid to eugenicist population policies that focused on limiting reproduc-tion, especially among the poor and people of color (Hartmann 1995).

This often led to coercive practices since the primary goal was to prevent these groups from having children, at any cost. Many women were sterilized without their knowledge or consent. Others have been pushed to using long-acting hormonal contraceptives such as Norplant and Depo-Provera, without being given information about potential damaging health consequences and side effects. Women have not been offered less invasive alternatives such as barrier methods of contraception, which also prevent the transmission of HIV/AIDS and Sexually Transmitted Diseases (STDs).

Unfortunately, the fight for legal abortion has too often been associated with these population control policies. Some organizations are pro-choice because they believe that overpopulation is the cause of global poverty, environmental degradation, and ethnic conflict. For these groups, legalizing abortion is a strategy for reducing the number of people in the world. This thinking is also prevalent in sections of the environmental movement and among some governments and NGOs in the South (Bandarage 1996: 6). Women of color throughout the world have historically criticized the racist aspects of these population policies.

By a failure to provide necessary supports for their mothering, and also through policies that actively undermine their ability to take care of their children,[13] population control policies devalue reproduction by women of color. For example, women from developing countries who come to the US and Western Europe as low-paid nannies for more affluent families are prevented from bringing their own children with them because of restrictions on immigration. Today, the lack of government subsidized childcare and restrictive welfare policies, such as those requiring women to work outside the home even if they have young children, make it difficult for low income women of color in the US to support their families; they also send a clear message that they are not supposed to have children. The global recession will pose yet more problems for women from poor and disadvantaged communities, and increase their numbers, with profound consequences for their health and the health of their children.

However, along with restricting support, some state and local governments in the US have adopted a more directly punitive approach, increasingly using the nebulous concept of "fetal rights" to criminalize pregnant women. Over 200 women have been prosecuted for drug use during pregnancy, and for other behaviors that allegedly threaten the health of the

fetus. These prosecutions disproportionately affect low-income women of color who are more likely to receive health care in urban, public hospitals where they are subjected to increased state scrutiny and interference. The majority of women charged with "prenatal crimes" are poor and African American. The threat of prosecution keeps many women away from seeking prenatal care, medical care during delivery, and follow-up care. This results in an increased number of unhealthy babies and unhealthy women. Public health and women's advocates point out that if the goal were, as the supporters of such policies claim, to insure healthy women and healthy children, the approach would be very different. Drug treatment rather than jail time would be offered. As it stands, there are few treatment options available to drug-addicted pregnant women, and in many locales, none whatsoever.

These issues, which are so central to the ways in which women of color think about reproductive rights, have not historically been part of the mainstream pro-choice agenda. Groups organized by women of color, including the National Black Women's Health Project, Women of All Red Nations, the National Asian Women's Health Organization, and their allies, have criticized the lack of attention from mainstream pro-choice groups to the issue of involuntary sterilization and other forms of coercive contraception (Silliman et al. 2004). These groups have situated the right to have children and opposition to population control at the heart of their agendas. They have been critical of the mainstream pro-choice movement's sole emphasis on the right not to have children when, for many women worldwide, it is the right to have children that is under attack.

CRITIQUE OF CHOICE

The movement that fought for the legalization of abortion in the US de-mobilized after it was achieved in 1973. Later in the same decade, the movement that emerged in response to the newly-formed anti-abortion movement was a defensive one. Momentum seemed to have shifted as the religious Right gained more power. Abortion rights supporters decided to use the language of choice and privacy as their framework. They thought this would have wider appeal and would broaden their base of support, encompassing even those who were more conservative on issues of social

and economic welfare (Silliman et al. 2004: 30). This approach was suc-
cessful in the short run, insofar as it temporarily split those on the Right.
However, it undercut demands for public funding of abortion and other
aspects of access that had characterized the earlier struggle for abortion
rights.

Framing abortion rights in terms of a woman's right to choose is prob-
lematic on other counts as well. Because "choice" appeals to those who
have options, but is relatively meaningless to those who do not, it is pol-
itically divisive. In a capitalist context, the idea of choice invokes the
marketplace—things that are for sale can be chosen. This neo-liberal
notion locates rights within an individual and obscures the social context
and conditions needed in order for someone to have and exercise rights
(Silliman and Bhattacharjee 2002: xi). The fact that race and class
inevitably circumscribe one's choices is ignored. Together with a failure to
oppose population control, making abortion a matter of choice re-enforces
the disparity between predominantly white and middle-class women who
are seen as the champions of abortion rights, and low income women and
women of color worldwide who bear the brunt of restrictions.

Not only is "choice" inadequate to express the full range of needs and
conditions which must be met if women are to be able to make their own
reproductive decisions; it is also a weak ethical framework, especially
when counter-posed to "life". The attempt to cast supporters of repro-
ductive choice as anti-life should be resisted by raising the life issue on
the abortion rights side. This means bringing the full reality of women's
lives to the discussion.

Choice has also been used to silence concerns about women's health
and potential coercion in the area of new reproductive technologies,
including contraception. For example, Norplant was the first new con-
traceptive to be introduced into the US in 25 years. It was met with rela-
tively uncritical approval by mainstream women's groups who saw it as
expanding women's contraceptive options. Depo-Provera, too, has been
seen as providing women with greater choice. Criticisms of these con-
traceptive methods, raised by women's health advocates in other countries
and women of color in the US, were dismissed by mainstream pro-choice
advocates who feared they would provide support to opponents of abor-
tion and contraception and thus undermine women's right to choose.
Criticisms were therefore often dismissed.

Human embryonic stem cell research has been in a similar position. The Right and the anti-abortion movement are ideologically opposed to it on the grounds that a fertilized egg is used in the research. In 2001, President Bush outlawed federal funding for all but a very limited category of such research. Many Republicans, however, including some of those who oppose abortion, did not agree with Bush's position on human embryonic stem cell research, a "wedge" that Democrats used to divide the Republicans. Proponents of such stem cell research have portrayed opponents as religious ideologues who would prevent science from finding cures for diseases. High-profile Republicans such as the wife and son of former President Ronald Reagan support it as it could provide cures for Alzheimer's, a nerve degenerative disease that Reagan suffered from. Individual US states such as California and Massachusetts have passed legislation allocating state funding for human embryonic stem cell.

In the highly politicized context of abortion, both these positions are too narrowly drawn. One can either side with science by supporting human embryonic stem cell research, or be anti-science by opposing it. There is no room for concerns about the potential risks to women's health. One such group, the Pro-Choice Alliance, has been arguing for another approach. While they support most human embryo stem cell research, they are also raising important objections to the process of embryo cloning involved in some lines of research. Specifically, they are worried about the risk to women's health from the extraction of the many eggs that embryo cloning requires. They argue that because of incomplete knowledge about the risks to women's health, women cannot give their informed consent to such extraction. They have advocated a series of measures designed to protect women's health, which include requiring researchers to adopt the safest and most ethical approaches to collecting eggs; ensuring a neutral party is involved whose sole purpose is to protect the safety and rights of women; reviewing existing data before undertaking multiple egg extraction; and ensuring that every woman who provides her eggs for research (rather than to have a baby through IVF) have her own physician, independent of the researchers (Center for Genetics and Society 2005). Groups such as these have been striving to create a more balanced public discussion, one in which women's health does not take a back seat for fear that opponents of abortion will win the day. In the process, they have been raising awareness and opening space for people to be both supportive of abortion rights and critical of technologies that pose potential health threats.

As with abortion, the election of Barack Obama as US President has brought some changes to this area. On March 9, 2009 he signed an executive order lifting the restrictions on federal funding of human embryonic stem cell research, although the detailed regulations as to what can and cannot be federally funded were still to be decided as of April 2009.[14]

ORGANIZING FOR REPRODUCTIVE JUSTICE

Historically, women of color have organized for reproductive and sexual rights outside of the "choice" framework. They have created their own organizations and coalitions, and have re-defined reproductive rights in ways that emphasize the needs of their communities. Overarching socio-economic inequalities and racism shape these communities and the lives of their women. They have disproportionate rates of poverty, lack of access to health care services and information, high incidences of violence, and poorer health outcomes in all areas. Examples include the fact that the majority of new HIV cases in the US are among African American and Latina women; Native American women experience very high rates of reproductive tract infections; Latinas have proportionately higher rates of cervical cancer; and Asian American women have been the only group to experience a rise in overall cancer mortality. Consequently, their definitions of reproductive justice focus on achieving the broad set of conditions necessary for reproductive and sexual freedom and health. Human rights and economic justice become part of this analysis, not separable from reproductive rights. Their definitions provide expansive understanding of reproductive freedom, which integrate the race, class, gender, and cultural aspects of their lives. Because of the histories of population control, the right to have children and families is core to their activism.

For example, Native American women and Latinas have both faced systematic coercive sterilization by the US government (Roberts 1997: Chapter 2; Roberts 2004: Chapters 6 and 12). Therefore, since the 1970s, their reproductive rights organization has emphasized opposition to sterilization abuse. Through their efforts, the US government was forced to adopt guidelines for sterilizations in public hospitals, which require women's genuine informed consent and mandate waiting periods.

Although there has been a lack of monitoring and enforcement, this was an important step toward stopping coercive practices.

Many of the groups founded by women of color have adopted the language of reproductive justice to emphasize the link between an individual woman's ability to control her own sexual and reproductive life and her community's efforts to regulate and control itself. For example, Native American groups, whose land and water has been polluted, make environmental justice central to their organizing. The Mother's Milk Project is an inspiring example of women's activism which joins reproductive and environmental concerns. This project on the Mohawk reservation in Akwesasne in New York state documented the toxicity of local waters due to corporate dumping of chemicals. Further, they publicized their findings and warned pregnant women not to eat fish from the river. At the same time, they have continued to press for the river and other toxic sites to be cleaned up. This example illustrates that struggles for sovereignty over land, and against environmental destruction, are part of reproductive rights. Mohawk women see women's bodies as the first environment that is not separable from the external environment.

This reproductive justice approach is in sharp contrast to the narrowness of mainstream pro-choice politics. It is a holistic formulation, which links communities and issues and therefore has a greater potential to draw new constituencies to the reproductive freedom struggle. Despite Obama's election, this is still important because the mainstream reaction from Democrats over the past few years in the face of the Right's power was to become more conservative. In recent years several leading Democrats called for the Democratic Party to become more hospitable to opponents of abortion. Senator Hillary Clinton's version of this approach was to describe abortion as "tragic" (Saletan 2005).

We should know better. Abortion rights are important both symbolically and practically since the availability of safe abortion has a direct impact on women's lives everywhere. A woman's bodily autonomy and integrity is at the core of self-determination and liberty. This is eloquently framed by the Johannesburg Initiative:

> In the context of gender inequality, where sexuality and reproduction are frequently not issues over which women are able to exercise control, abortion serves as a way out . . . At the present moment, the right to choose and access abortion is an absolute prerequisite for women to be

able to exercise their human rights. Without abortion access, women cannot exercise their freedom and cannot live as full citizens. For this reason, the struggle for abortion rights sits at the heart of the women's rights and health movement. (Klugman and Budlender 2001: x, xi)

Removing women's rights and sexuality from the abortion struggle and pursuing a narrow agenda has not been a winning strategy in the long run. It has perpetuated racial and class divisions in the women's movement, weakening the ability to resist threats and to move forward to secure rights never achieved. Reproductive justice should become the central frame for reproductive rights, not only because this is the right thing to do, but also because it is the only way to win.

NOTES

1. "Experts believe that about one-third of women undergoing unsafe abortions experience serious complications, yet fewer that half of these women receive hospital treatment" (Allan Guttmacher Institute 1999b).
2. Women on waves. 2005. "Every 8 Minutes a Woman Dies Needlessly as a Result of an Unsafe Illegal Abortion", *Facts*. Available online at http://www.womenonwaves. org/article-115-en.html. Accessed on May 21, 2005.
3. The Johannesburg Initiative was organized by the Women's Health Project (WHP) in Johannesburg, South Africa, to build capacity for expanding abortion advocacy and to share national experiences among countries from diverse regions. For more information, see Klugman and Budlender (2001).
4. The legislation signed by George W. Bush on March 21, 2005 gave federal courts jurisdiction to review alleged violations of Terri Schaivo's constitutional rights, superceding previous rulings from the Florida state courts that she would not wish to continue life-prolonging measures, which had led to her feeding tube being removed on March 18, 2005. Despite the Bush legislation, Schaivo's feeding tube was not reinserted and she died on March 31, 2005.
5. Abortion was legalized in the US in 1973 with the *Roe vs. Wade*, a decision of the US Supreme Court, *Roe vs. Wade,* 410 US 113 (1973).
6. The 2004 study indicated that 30 US states were poised to criminalize abortion if *Roe vs. Wade* was reversed. Many have pre-*Roe* abortion bans on the books that could be revived, some in a matter of weeks. Since 2004, a new strategy has emerged: bans-in-waiting that would criminalize abortion the instant *Roe* was overturned, and immediate bans that criminalize abortion as soon as they are signed into law and that are intended to force the Supreme Court to reexamine *Roe*. Since 2004, 38 immediate bans have been introduced in 17 states and four bans-in-waiting in Louisiana, Mississippi, North Dakota, and South Dakota. See Center for Reproductive Rights (2007).

7. The State Department was added in 2003.
8. The "morning-after pill" (two 750 μg levonorgestrel pills) has been available in the US with a prescription since 1999.
9. In other cases, people who are professionally unqualified or who have conflicts of interest have been appointed to official posts or advisory committees. Abortion and sexuality are not the only casualties. For example, a scientific advisory committee on preventing childhood lead poisoning included a member on the payroll of the lead industry and another who had been nominated by the industry (Integrity of Science Working Group, Science and Integrity 2004). In another example the Bush administration altered language in research reports to create the false appearance of uncertainty about global climate change. (For more on this, see Union Of Concerned Scientists 2004). For other documents on scientific integrity see http://www.ucsusa.org/scientific_integrity/.
10 The common features of junk science include equating correlation with causation; use of "studies" that lack controls; and systematically misinterpreting other people's research.
11. Some of the inaccurate claims identified by the report were: a 43-week-old fetus is a thinking person; women who have abortions are more prone to suicide; HIV can be spread through sweat and tears; and that condoms fail to prevent STDs 31 percent of the time.
12. Efforts to control fertility have been a persistent feature of politics aimed at both women and men of color, sometimes attempting to increase their fertility, but most often aiming to limit it.
13. Welfare Reform in the US, passed by the Clinton administration in 1995 is another form of eugenics since it prohibits increases in payments to poor families even if they have more children.
14. In April 2009, the National Institutes of Health issued draft guidelines that advocated permitting federal support for research with stem cell lines derived from embryos created during fertility treatments but not used, but not permitting support for research on stem cell lines derived from embryos created with cloning techniques. For more information, see http://www.geneticsandsociety.org/.

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5

An Entangled Skein: Neo-Malthusianisms in Neo-liberal Times

Mohan Rao

More than a decade after the "historic" Cairo conference where do we stand today? Is it significant that there was no decennial conference in 2004? Why did this not take place? Did Cairo mean anything at all to ideas, and indeed prejudices, about population? How did these get entangled with current politics over the years? In the years since Cairo, of course, the world has changed significantly, but for some things, the more they change, the more they remain the same.

Politically correct, influential people in policy-making circles in the First World do not, any more, talk of the yellow peril, or use phrases such as population explosion, or metaphors like the population bomb. Nevertheless, neo-Malthusian thinking frames other policy discourses, those on immigration and the environment being prominent ones.[1] At the same time, partly due to the very reach and influence of such doomsday demographic discourses emanating from the West in the past, and the modified ones today, the elites and the middle classes in much of the Third World remain convinced that the cause of social and economic problems in their countries stem primarily, if not only, from population growth.

On July 30, 2003, a three-judge Bench of the Supreme Court of India, for example, upheld a Haryana government law prohibiting a person from contesting or holding the post of a sarpanch or panch in the Panchayati Raj Institutions (PRIs) of the state if he or she had more than two children. The Bench observed that "disqualification on the right to

contest an election for having more than two living children does not contravene any fundamental right, nor does it cross the limits of reasonability. Rather, it is a disqualification conceptually devised in the national interest" (Venkatesan 2003: 1).

Interestingly, while the Supreme Court spoke about the "torrential increase of population", earlier the Rajasthan High Court judges, hearing a similar set of petitions, in their ruling argued: "These provisions have been enacted by the legislature to control the menace of population explosion" (Sarkar and Ramanathan 2002: 42). It is, of course, clear that neither the Supreme Court of India nor the Rajasthan High Court were moved by the "paradigm shift" at Cairo. In addition to these two states, other states such as Madhya Pradesh, Uttar Pradesh (UP), Andhra Pradesh, Himachal Pradesh, Chhattisgarh, and Orissa also have, or have had, such a law on their books.[3]

The Supreme Court ruling came in for widespread middle-class approbation. Indeed, the Supreme Court ruling perhaps renders redundant the twenty odd private member's bills in Parliament that have been tabled to increase incentives or disincentives to control population.[4] All these were, of course, at fundamental variance with the National Population Policy 2000, framed in response to Cairo.

These efforts at prescribing a two-child norm seem to be found also in unlikely quarters. Straining credulity, the Tamil Nadu agricultural laborer's insurance bill stipulates that laborers losing their limbs can only receive insurance compensation if they have no more than two children. The Maharashtra government passed a law authorizing differential irrigation fees; farmers with more than two children would be required to pay more for irrigation facilities (*The Hindu* 2005). More creatively, the UP government announced a scheme whereby applicants for gun licenses had to produce certificates that they had motivated five cases for sterilization. Meanwhile, a delegation from the Indian Medical Association has urged the government to, following China, implement a One Child Norm (Kurup 2005). Getting into the fray, the Election Commission of UP has suggested a two-child norm for all electoral posts.

It is obvious that the winds of Cairo have not blown here, despite all the efforts of UNFPA and a host of organizations funded by, and including, institutions like the IPPF, the Population Council, and the Ford and MacArthur Foundations. It is also clear that these initiatives stem from an

anxiety among elites about population growth in the country, the belief that population growth lies at heart of a range of social and economic problems that we face. This belief enjoys widespread appeal in the media and among middle-class professionals, including, of course, doctors. What explains the enormous appeal of this argument? Is it propaganda over the last 50 years, initially stemming from the West, but now deeply internalized in our country?[5]

The issue of population is, of course, a field where a rational and historical examination of facts is often clouded, occluded, rendered opaque. Neo-Malthusian arguments are truly protean, they are like Vishnu's avatars, taking myriad forms: that poverty in our country primarily persists due to population growth; that the poor do not know what is good for them and for society as a whole, behave irrationally, and thus need to be educated; that population growth among religious communities is because some religious groups seek to outbreed and take over "our" country; the belief that affirmative action for the Dalits presents a threat to social well-being and indeed, that all welfare schemes represent a waste of productive investments; that "we" as a nation are in a bind, and, having tried everything, the only way out is that the poor can and indeed must be coerced to control their numbers; that population growth represents the main threat to the environment; that population growth in Third World countries can act as a security threat to the interests of freedom and democracy in the world, and so on. Now of course, with the global war on terror, youth bulge theories have contributed to, and drawn sustenance from, global Islamophobia. Lurking at the heart of all these discourses, crazily, simplistically, is the idea of neo-Malthusianism, a simple arithmetical one.

Many of these beliefs are sanitized in public pronouncements, made acceptable, and yet it is undeniable they represent powerful undercurrents of thinking in an astonishingly wide range of areas. This chapter, preliminary and tentative in nature, attempts to explain what seems to be inexplicable. Do these ideas stem from other atavistic anxieties, about tribe and race? Do they arise from their evident simplicity in explaining a deeply fractured world? Why are they such overwhelming tropes in the discourse of fundamentalisms of various sorts? Does neo-liberalism provide them with impetus? Why are they entangled with other anti-feminist discourses? How do issues of identity, currently *au courant*, get imbricated in this?

I begin, then, with the almost irrelevant, if achingly tantalizing, question: what explains this abiding and widespread belief in neo-Malthusianism? This question, though terribly moot, is difficult to answer with any certainty, since it involves feelings, opinions, and prejudices that are not always easily explicable. How does one, for example, explain racism? Or, in India, the profound hold of casteism, the hatred and distaste for the lower castes, especially Dalits? Or, the recent growth of suspicion, anxiety, and indeed, hatred and fear, for anything to do with Islam? There are many and complex reasons for this and some inter-linked. Is it primarily about with economic factors? It is obviously not only to do with economic factors, although these are no doubt contributory. There are many more reasons, and population arguments also feed into this: the creation and hardening of prejudices, and of fear. In neo-imperial times, creation of fear is a growth industry (Lipschutz and Turcotte 2005) with sometimes utterly transparent political ends.

EXPLAINING NEO-MALTHUSIAN FEARS

At the most obvious level as to why people believe what they do, it is true that many people have, for hundreds of years, believed in something simply because this is "common sense". The belief that the earth is flat and that it is at the center of the universe is one such belief that lasted centuries, and still apparently has followers. This, of course, begs the question as to what is common sense and how this is created, or indeed constructed.

Neo-Malthusianism offers a simple ordering of a complex, fractured, and frightening world. In this ordering of the world, God is indeed in His heaven and all would be well had it not been for the predilection of the poor, the Them, to breed quite so incontinently. It is a profound alchemy of the mind that endows society with biological characteristics, all the better to control and recreate it. It allows us to think of the world without dangerous ideas of re-ordering a deeply unjust social order, indeed blaming victims, the "them", who would otherwise threaten "us" with their demands for equality and justice. It is not only a beguilingly simple explanation of the world, this explanation has the imprimatur of the state with all powerful organs of dissemination of knowledge and information constantly reiterating and restating it in a number of ways. Indeed, it might

perhaps not be an exaggeration to state that more resources have been spent on creating this common sense over more than a hundred years than any other such idea in the world. Lurking below the surface, these ideas have always a strange way of resurfacing in what are perceived by some as incomprehensibly apocalyptic times, when the world as we know it stands threatened, or is changing too fast for our liking, when we yearn for a prelapsarian age of innocence and glory, when things were said to have been so much simpler. Thus, the re-invention of tradition (Hobsbawm and Ranger 1983), the entirely understandable fear of the heartless immorality of the modern, indeed of the demands of the hitherto dispossessed, which is also fundamentally part of this modernity.

Yet another factor is the ease, or the appeal, of linear or closed system thinking. It is thus not surprising that so many biologists, equating human societies with agglomerations of mango-flies or other instinctive creatures, frequently offer doomsday scenarios of population growth, as if humans are not reflexive, learning, reacting, eternally changing.

Nothing perhaps is more appealing to crude "common sense" than the many images of humankind such thinking creates: the image of human societies as crawling, over-breeding insects in a finite jar, or of organisms in a petri dish. But the imagery is not always crude, appealing to the most insentient in us. Most such images of the population question undoubtedly appeal to the altruistic: the images of starving children, hungry mothers, eyes powerfully accusing, along with the message of overpopulation. Indeed, we are then exhorted to do something about it by contributing to population control in Third World countries. What many of these images also appeal to is the immediate, the un-reflexive, thus a-historical, in a world profoundly troubled by history and impatient with it.

We begin, then, with a brief genealogy of neo-Malthusianism. Genealogies are fundamentally about accepted, legal marriages and births. The late 19th century marriage of colonial anthropology with craniometry and the "science" of "race" produced the "science" of eugenics. Framing these disciplines, it must be noted, was the reality of colonialism that mid-wifed and nurtured these disciplines. Eugenics, of course, is a parent of neo-Malthusianism and of socio-biology. The American anthropologist D.G. Brinton argued, in praise of anthropometry:

> The adult who retains the more numerous fetal, infantile or simian traits is unquestionably inferior to him whose development has progressed beyond

them. Measured by these criteria, the European or white race stands at the head of the list, the African or Negro at its foot. (Brinton 1890 cited in Gould 1981: 116)

Thus, anthropology taught us, and anthropometry and craniometry quantified, the following: natives and savages were child-like, effeminate, instinctive, sensual, unreflexive, irrational, less intelligent, and in thrall of customs and traditions. Strangely, they were also hyper-sexual and thus tended to breed too much. In Kipling's words, they are half-devil and half-child, sullen *new-caught* people.[6] They were, of course, to be "The White Man's Burden", incapable of self-rule. At the same time, psychology also showed us that "the metaphysical character of women was very similar in nature to those which men exhibit at an early stage of development. The gentler sex is characterized by a greater impressibility, warmth of emotion, submission to its influence rather than that of logic" (Gould 1981: 117). Blandly stated, racism, anti-feminisms, and colonialism come promiscuously together, with the colonizer to send forth the best he breeds to quell the sullen natives.[7]

Armed with these insights, eugenics set out to improve the human race through two policy prescriptions: decreasing unwanted populations through negative eugenics, that is, not permitting populations that exhibited undesirable characteristics to breed; and providing incentives to the best and brightest to breed through positive eugenics. The victims of negative eugenics have been the "feeble minded", the tubercular, the alcoholic, the "indigent", the "congenital criminal", the mentally retarded, the insane, lepers, epileptics, the "feeble minded", the "degenerate", immigrants, and of course the poor, who apparently bred all these characteristics, especially if they were black or colored. All this, with the supreme imprimatur of science. In this case of course science was like theology, unquestionable. Benjamin Franklin noted, "I could wish their numbers were increased. Why increase the sons of Africa, by planting them in America, where we have so fair an opportunity, by excluding all blacks and tawneys, of increasing the lovely white and red?" (cited in Gould 1981: 32).

According to Francis Galton, eugenics would breed out the vestigial barbarism of the human race, manipulating evolution to bring the biological reality of man in consonance with his lofty moral ideas of what mankind could, and indeed should be. He thus argued, "what nature does blindly, slowly, and ruthlessly, man may do providently, quickly and kindly"

(Galton 1904 cited in Kevles 1995: 12). Eugenics was thus a scientific substitute for the orthodoxies of the church, a secular religious faith. Eugenics was also tied to the destiny of the imperial nation. Such a nation, it was felt, required much more than merely economic and military power. It also demanded an efficient way of ensuring that its population was kept fresh, energetic, efficient, and productive by ensuring that its fresh flow of population is mainly recruited from the "better stock" (Rao 2004). Indeed, this was one strong impetus to introduce maternal health programs in many countries (Oakley 1986).

A prominent eugenist in Germany wrote:

> Because the inferior are always numerically superior to the better, the former would multiply so much faster—if they have the same possibility to survive and reproduce—that the better necessarily would be placed in the background. Therefore a correction has to be made to the advantage of the better. The nature [*sic*] offers such a correction by exposing the inferior to difficult living conditions which reduce their number. Concerning the rest the nature [*sic*] does not allow them to reproduce indiscriminately, but makes a relentless selection according to their strength and health conditions. (Hitler 1925 cited in Bondestam and Bergstrom 1980: 16)

The "correction" he offered to nature's lethal ways was called the Final Solution. Adolf Hitler included, among others, Jews, communists, gays, and gypsies in his grand design.

It was this, the Final Solution, that discredited eugenics, although the ideas underlying it were widely shared indeed (Brunius 2006). Further, as Brunius shows us, eugenic laws, framed by racism, were widely welcomed by the medical profession, the media, and by lawmakers; they also received the approval of the US Supreme Court.[8] But similar attitudes, similar feelings come to surface in many new avatars, all too distressingly frequently. In other words, it is the current political context that this idea appears to address, as it waxes and wanes, sometimes shrill, sometimes subdued, but at all times invariably, inextricably, linked to contemporary politics. Numbers of the other provide the *frisson*.

As the eminent German poet Enzenberger notes, the proportion of foreigners in Germany at the end of the 20th century—when vicious anti-immigrant ideologies came to the fore, often accompanied by brutal attacks on "foreigners"—was well below that in the Germany before the First World War, when there was no such xenophobia. In Germany, itself

a country of migrants, of many "races", "The Aryan was never more than a risible construct" (Enzenberger 1992: 38). Enzenberger adds:

> It is of course no accident that the image of the life-boat recurs in the political discourse about immigration, usually in the form of the assertion, "The boat is full". That this sentence is inaccurate is the least that can be said about it. A look around is enough to disprove it, as those who use it know. But they are not interested in its truthfulness; *they like the fears it conjures up.* (ibid.: 24) (emphasis mine)

Yet, Germany is one of only two modern states that allow its "lost tribes" a right to return. Israel is, of course, the only other. Two nations tied by a complex history of brutal bloodshed, both believing that nationality is in blood, both riding the tiger of fascism at various times, Germany in the past, and Israel, today. Tying in with this idea, or sometimes even a metaphor of nationality, is the essentialism of numbers. This essentialism of numbers is in a potent stew with the urge for the authentic and unsullied, and in the politics of identity creates fears about the numbers of the Other. Again, these have a heritage in romantic Germany that so influenced the romance of a nation-in-being in India in the Rashtriya Swayamsevak Sangh (RSS) (Nussbaum 2007), with the military organization being borrowed from Mussolini's brown-shirts (Casolari 2000).

There is today in neo-liberal times a reified politics of identity, feeding into neo-Malthusian anxieties. There is a paradox here: while neo-liberalism exalts and celebrates the individual, identities are increasingly drawn in communitarian terms, and carved in heartless stone. Sen notes wryly that we have today a "discipline of identity" based on the unfounded assumption that we must have a single or principal identity that we "discover" (Sen 2005: 350). Of course, this discovery is most often of a spurious ethnic kind, forgetting that the ethnic or the nativist is only one among many claims to loyalty, and indeed that there is frequently nothing authentic either about imagined ethnicity.

Wedded here are essentialisms of various kinds: nativist post-modern, with fundamentalist neo-Orientalism, with right-wing neo-liberalism. Uniting all these essentialisms is also a fervent anti-feminism, seen as tarnished by the Enlightenment project, anti-traditional, and derivative (Sangari 2001). It is thus no accident that the Islamic Brotherhood in Egypt (Ali 2002), the murderous Hindu fascists, and George Bush echo each other in derivative irony. Entirely missing in these discourses is the notion

of imperialism or neo-imperialism, which indeed gilds them, even as it holds them together.

The uncanny similarities between Malthusian times and the 1990s have been widely noted. Both periods were characterized by a relentless drive to create free markets:

> . . . not by chance nor as a result of spontaneous development, but as an artifact of power and statecraft. In nineteenth century England it was the outcome of the project of classical political economy; now it is a monetarist project, to create a global market society largely unconstrained by public action. (Wuyts 1998: 34)

This new global market was to be created by the second wave of imperialist globalization enveloping the world led by the Bretton Woods institutions, with new rules framed by the WTO. Imperialist globalization sups comfortably at the same table with fundamentalisms; while doing so it also feeds it fresh blood. This is not only through the empirical truth that imperialism has funded fundamentalisms in various countries (Mamdani 2004), but also by fracturing broader identities, in a situation of a smaller cake for the masses, encourages the growth of political forces that feed on each other, along ethnic or religious lines (Patnaik 2003). From Yugoslavia, to Rwanda and now Iraq: the same story authored by imperialism unfolds sadly (Mamdani 2001). Population arguments have contributed in all of them, appealing to community, to race, ideas of purity and blood. In all these cases, blood is defined by patriarchy.

What is frightening is that the atavistic appeals to blood, to tribe and to race, seem to carry so much power when we finally know there is no such thing as race. Current post-modern distrust of the modern state, and its violence, and the invocation of naive nativism feed their poison into this. Thus Algeria for the Algerians—who should not be in France! But in a world where historic revisionism is current, where new "tribal wars" are unleashed everyday[10] with the coining of a new and frighteningly aseptic phrase to describe it, ethnic cleansing, it is eminently desirable to retrace the links between neo-Malthusianism, eugenics, and the Holocaust. It is an irony of history that victims of the Holocaust, in one of the first modern countries created on the basis of religion, in order to supposedly protect their "race" are perpetrating yet another one today. Thus, the population growth rate among Palestinians is frequently evoked in order to stoke fears among Israelis who are not Zionists (Avnery 2002 cited in

Hartmann and Hendrixson 2005). By engendering fear and anxiety about the future, what neo-Malthusianism successfully does is evoke complicity in morally offensive policies among people.

The collapse of multi-national states as in Yugoslavia, the yearning for ethnically pure "nations of blood and ties" that caused and were a consequence of this collapse, have something tragic to teach us. The horrible implications for huge sections of the population, ethnically cleansed into post-colonial states that have forgotten their anti-imperialist histories, is too recent to be forgotten.

Ethnic nationalism, combined with the essentialism of numbers, implies that "one is in the grip of a love greater than reason, stronger than the will, a love akin to fate and destiny. Such a love assists the belief that it is fate, however tragic, that obliges you to kill" (Ignatieff 1993: 10). History is then reworked to create the fiction of ethnic purity in the past, in which "history is the savage play of ascriptive sympathies and antipathies, in which the 'natural' condition of groups of different origins is one in which they are wholly apart" (Al-Azmeh 1993: 9).

Thus, invoked in the rape and genocide of Muslims in Bosnia is the appeal to concocted history, to ethnic tribalism in all its gory, and ancient, essential symbols:

> Miraculous Virgins make their scheduled appearance. Lurid posters show shafts of light touching the pommels of mysterious swords, or blazoning the talons of vicious two-headed eagles as more than a million Serbs attend a frenzied rally on the battle site of Kosavo where their forbears were humiliated in 1389, and hear former communists rave in accents of wounded tribalisms. Ancient insignias, totems, feudal coats of arms, talismans, oaths, rituals, icons and regalia jostle to take the field. A society long sunk in political stagnation is convulsed: puking up great rancid chunks of undigested barbarism. (Hitchens 1992 cited in Al-Azmeh 1993: 10)

The politics of nostalgia, of fictive identities, swirling with unresolved conflicts with neo-imperialism, create post-modern states painfully emulating the nation-states imagined in Romantic Germany, as a nation of *volk*, of people of the soil, of primordial ties embedded in an ancient culture, in a fierce anti-Enlightenment discourse. This is of course eerily familiar to those of us in India who are witness to pogroms against Muslims launched by the Sangh parivar.

The onslaught against the Muslims is accompanied by a concoction of history, which is a mélange of myths and fiction, and also accompanied by the invention of "traditions", the classification of Indian culture as "essentially" Hindu culture, and so on. Fundamentalist demography is built upon these layered tissues of lies and populist myths to create a political community of Hindus. As with all fundamentalisms, these are also carved on the bodies of women. Internalizing—with bewilderment, hurt, and anger—colonial descriptions of Hindus as effeminate, the new identity that is sought to be created is virulently masculinist.[11] Along with the semitization of Hinduism (Jaiswal 1991), there is an attempt also to make Hindu males more virile, more dangerous, more predatory, more like the allegedly Muslim male. Could this explain the huge increase in violence against females that we have also simultaneously witnessed?

As Malouf has observed, the rush for identities, to seek some fundamental allegiance, often religious, racial, or ethnic, leads to murderous identities of blood. Responding to imagined atavistic fears and anxieties, we seem to be heading toward what Malouf describes as the age of "global tribes" (Malouf 2001).

Imbricated in this is the celebration of the pure "community" even as ideas of the nation are scoffed at, when development is supposed to be automatically and necessarily linked to violence. This is accompanied by a deep distrust of ideas of rationality, curiously described as Western, in a bizarre reflection from Orientalist mirrors. Embedded in this discourse are spurious ideas of oneness with nature in the pre-modern past, of equally innocent ideas of the wholeness in human affairs in those golden ages, a forgetting that a tribal past was a past of constant and continuous warfare. In short, that a tribal past, an ethnic past, a past celebrating blood ties, was above all oppressive to a large majority of women and men, the ants of these societies, put to labor, and set to breed. My fear is that revocations of this past, suitably re-worked, would also mean a divestment of citizenship rights that tribal communities, of course, did not know about, or have any use for. For as opposed to the membership of a tribe, what is at stake is citizenship in a nation.

Sometimes, in sophisticated formulations, instead of race and tribes, what is often invoked today is "culture", reified, petrified, timeless, and endlessly frozen. As Al-Azmeh observes:

> In the 1980s this relegation of the non-European world to irreducible and therefore irredeemable particularlism was officiated, with increasing frequency and clearly as a mark of bewilderment, under the title of "culture", which became little more than a token for incomprehension: each "culture" is represented as a monadic universe of solipsism and impermeability, consisting in its manifold instances of an essential self. (Al-Azmeh 1993: 21)

The politics of the east is east and the west is west with never the twain meeting is played out with new tropes, new metaphors, all of which, of course, elide the reality of imperialism, even as they privilege the essentialisms of difference and timeless culture. The Other, thus constructed, is then ineluctably outside the human pale. And then, their numbers begin to threaten. Should we, then, not fear "them", hate "them"? Should we do nothing, will they engulf "us"?

Being outside the human pale is what makes their numbers threatening and genocide possible (Mamdani 2001).[12] The widespread rape and violence against women and children—from Bosnia, to Rwanda to Gujarat is another effect.

Lionel Penrose, a British physician who was one of those questioning the central tenet of eugenic thinking, the heritability of mental disorders and intelligence, was equally puzzled by the frequent assertion among the elites that feeble-minded people had strong sexual drives. There was simply no empirical evidence for these claims, and yet there were frequent calls for eugenic sterilization—although, of course, sterilization is known not to decrease the libido. Penrose offered a Freudian explanation that is appealing. He wrote:

> It is a well-known psychological mechanism that hatred, which is repressed under normal circumstances, may become manifest in the presence of an object which is already discredited in some way. An excuse for viewing mentally defective individuals with abhorrence is the idea that those at large enjoy themselves sexually in ways which are forbidden or difficult to accomplish in the higher strata of society. The association between the idea of the supposed fecundity of the feeble-minded and the need for their sterilization is apparently rational, but it may be emphasized by an unconscious desire to forbid these supposed sexual excesses. It is of course well known that advocates of sterilization never desire it applied to their own class, but always to someone else. (Penrose 1933 cited in Kevles 1995: 108)

Could this equally be an explanation for neo-Malthusian ideas about the reproductive profligacy of the poor? Could this be the explanation for the irrational communal anxieties about the rate of population growth of Muslims among a section of Hindus in the country? The frequent slogan "Hum do, hamare do; Woh paanch, unke pachees" won the leader of the genocide in Gujarat in 2002 a shameful but resounding electoral victory. Does this also tie in with the trope of the alleged vegetarianism of Hindus along with the sexual rapacity of non-vegetarian Muslims?

Sarkar notes that "there is a dark sexual obsession about the allegedly ultra-virile Muslim male bodies and over-fertile Muslim female ones" (Sarkar 2002: 2874). Recounting the unspeakable horrors perpetrated on Muslim women and children in the Gujarat genocide, she offers the following explanations. In communal violence, rape is a sign of collective dishonoring of a community; the same patriarchy that views the female body as the symbol of lineage, of community, of nation—and their purity— would besmirch an entire community as impure and polluted once "their" women are raped. There are also the calculated and politically charged rumors spread of Muslim men luring away Hindu girls, "a kind of penis envy and anxiety about emasculation that can only be overcome by violence". And finally, the anxieties whipped up over generations about "Muslim fertility rates", of their uncontrolled breeding and the dying of "the Hindu nation". This led to the brutal killing of children, the new blood of the "Muslim race".

Nussbaum has argued that the creation of virulent masculinities is perhaps a part of the project of nationalisms of the European variety. Emulating this project other communities, other nations of blood and tribes, are also creating masculinities of the European sort. She notes that Israel and India are both seats of construction of this notion of virulent masculinities, both directed at Muslims, classified in colonial discourse as a "martial race". Those scoffed at as effeminate or over-intellectual, not manly enough to command empires, set out to recreate themselves in colonial mirrors, creating a style of masculinity that is associated with the oppressors in the past, much as they recreate colonial definitions of history. This, too, is responsible for the horrors of Gujarat, as is the essentialism of numbers, as they wreak murder and rape, "annihilating the female" both in themselves and in the other (Nussbaum 2007). Linking this sadistic

sexual violence with fascism, Sontag similarly argues that this was "the ideal incarnation of fascism's overt celebration of the righteousness of violence, the right to have total power over others and to treat them as absolutely inferior . . . acted out in a singularly brutal and efficient manner" (Sontag 1980: 99).

As early as 1909, U.N. Mukherji had written a book entitled *Hindus: A Dying Race*, which went on to influence many tracts and publications by the Hindu Maha Sabha, the parent organization of the RSS.[13] This book seemed to meet a widespread demand, going into many reprints, feeding into Hindu communalism, and helping create it. It had a special appeal to Hindu communalists, anxious to create a monolithic Hindu community, in the face of demands for separate representation emanating from both Muslims and lower castes. Whipping up anxiety about Muslims would be one way to weld together hugely diverse, and often antagonistic, castes into one community, erasing the structural divisions in caste society. Indeed it has been noted that "for Hindu communalism, it (the book, *A Dying Race*) had a more direct resonance as Hindu communalism was now preoccupied with numbers … the possibility of low castes de-classifying themselves as Hindus was a motivating anxiety behind the origins of Hindu communalism" (Datta 1999: 18). Deeply riddled with inaccuracies, wild flights of prediction of the future with utterly no basis, the book nevertheless provided "demographic common sense function-ing as a trope for extinction" (ibid.: 23). Also fundamentally, the Hindu communalists believed—and continue to believe—that a nation is defined "culturally" as a Hindu nation, just as Muslim communalists believed in the purity of an Islamic Pakistan. So the Hindu and Muslim communalists, by evoking demographic fears subscribed to colonial definitions of Indian society! The censuses of the period also contributed (Cohn 1987). We must, however, remember that this discourse emerged at an embattled political space, as colonialism was contested, as political classes were formed, as the working class was congealing, and early feminist ideas were gaining ground. None of these, of course, configure in the communalist discourse.

Charu Gupta's work, based on examination of the many tracts pro-duced by the Hindu right-wing, provides an excellent analysis of com-munalization of population and its gender implications. She notes one such tract states:

> Some Hindus argue that what do we have to do with increasing our numbers? We should be more concerned with preserving the seed of our true *Aryan identity.* Dear, what do you mean by protection of the seed? In every census, the number of Hindus is decreasing while that of Muslims and Christians is increasing. And you are just concerned with the protection of the seed! Our aim should be to increase numbers, first and foremost. (Cited in Gupta 2004: 4303)

There was yet another flame stoking these fears among Hindu communalists, resentful of social reform. Emblematic here was the tragic figure of the Hindu widow.[14] Remarriage of widows was forbidden in the upper castes. The Hindu widow was responsible for the dying of the "Hindu race" as she was an allurement for virile Muslim men, a danger within the sacred heart of the Hindu household, waiting to be profaned. Fitting neatly into this gendered anxiety was the communalization of the issue of "abduction" of Hindu women. Indeed, this too was prominent in the form of rumors before the Gujarat genocide in 2002. Thus, the embedding of patriarchy, nationhood, and violence against women in discourses on numbers. Together they inscribe on reproductive women's bodies atavistic anxieties about the future, and the politics of genocide.

Recently we have had leaders from these groups opposing family planning among Hindus, claiming there is a "demographic war" (www.newkerala.com 2004).[15] The leader of the VHP enjoined Hindus not to accept family planning as their numbers were going down, even as those of Muslims were increasing. At a public meeting attended by thousands, and in the presence of the Chief Minister of Madhya Pradesh, the leader of the Madhya Pradesh unit of the RSS claimed that the Muslim population was increasing at a rapid pace, and that this, combined with infiltration of Muslims from Bangladesh, portended doom for India. Claiming that this "demographic war" was being waged across the world, he attributed the break up of the Soviet Union, to such "demographic imbalance" (*The Hindu* 2005: 5). The same groups have also opposed access to abortion, arguing that a disproportionate number of Hindu women utilize abortion facilities (Rao 2001). We have also had a huge and unedifying controversy erupting recently when the Census Commissioner announced the religion-wise data from the 2001 Census, forgetting to add that these could not be compared to previous figures since the 1991 Census had not been conducted in Kashmir, a Muslim majority state (Jayaraj and Subramaniam 2004).

The Hindu right created an uproar about "them" out-numbering "us" in our own country, with a lot of help from the national media. This was despite clarifications issued by the Census Commissioner, despite figures showing that the rate of decline of the Muslim growth rate was substantial and indeed sharper than among Hindus. Indeed what has come to be called "saffron demography" has come to stay, "a set of pernicious myths" masquerading often as "common sense" (Jeffery and Jeffery 2005: 447).

In an extraordinary work, Anandhi reveals that in Tamil Nadu the neo-Malthusian concerns were influencing the upper-caste anxieties about the lower castes, who were now asserting themselves in different areas (Anandhi 1998). She notes the ease with which the upper class neo-Malthusian agenda interweaves with the upper caste agenda of Brahmanical Hinduism to reduce women to merely reproductive bodies requiring male control, in a reimbrication of patriarchy. A number of men—predominantly Brahmins, members of the Neo-Malthusian League in Madras in the early 20th century—who were involved in the early debates on birth control, invoked Brahmanical texts that apparently regulated the sexuality, and thus the birth rate, among Hindus. Thus was achieved the seamless welding of "Hindu" with upper castes, the conflation of upper-caste practices and norms as Hindu ones. Thus Krishnamurthy Ayyar noted that, in the case of Hindus, as per the code of Manu, certain marriage practices were anti-natal; surprisingly he does not mention a deeply embarrassing topic of debate, namely the situation of widows in upper-caste Hindu society. This apparently prevented overpopulation of Hindus, while conversely creating overpopulation of those communities not similarly guided by the code of Manu. He also added that the upper-caste dietary code of vegetarianism was perfect for regulating reproduction by dampening sexual appetites:

> Taking the people of India, the birth rate among the Brahmins, particularly those of Madras and other purely vegetarian communities is the lowest except among the Parsees.[16] The Mohammedans who partake of animal foods have increased from 1881 to 1921 . . . the Brahmins, who are purely vegetarian, there was no increase between 1891 and 1921, but a fall. (cited in Anandhi 1998: 143)

What was central to the arguments here were the reproductive excesses of the lower castes (and of the Muslims), their unbridled sexuality, the need, therefore, for upper-caste normative control defined in terms of desexualizing lower-caste bodies. As Chakravarthi has argued, what

Brahmanical patriarchy feared and indeed what was supposed to have brought on Kaliyuga was miscegenation, "the purity of women has a centrality in brahminical patriarchy, because the purity of caste is contingent upon it" (Chakravarthi 1993: 579). In short, the lower castes had to practice birth control both to improve the Hindu race and to emulate the upper castes who supposedly practiced continence, except for reproductive purposes.[17]

As Ayyar observed:

> As long as the germ cells belong to the race and human beings are their trusted custodians, birth control should not be resorted to unless it is for considerations of health or economic conditions. If it is practiced with the view to shirk responsibility and to lead a life of merely carnal pleasure, it is committing a crime towards the race. (Ayyar 1930 cited in Anandhi 1998: 144)

What is curious, and indeed striking, is that although there is anxiety about the sexuality of the lower castes, Hindutva does not seem to reveal obvious anxieties about the numbers of the lower castes. On the one hand, as the experience of Gujarat indicates, this could be related to the fact that Hindutva anxieties are largely focused on the growth rates of Christians and Muslims and that they see the Dalits and the lower castes as foot soldiers in their fratricidal war. On the other hand, this could be related to their obvious role as perhaps the sole producers of value. The statement of a landlord in Tamil Nadu to Human Rights Watch illustrates this:

> In the past, dalits enjoyed the practice of untouchability . . . the women enjoyed being oppressed by men. Ladies would boast that my husband has more wives. Most dalit women enjoy relations with men. They enjoy upper caste community men having them as concubines. Anything with dalits is not done by force . . . .Without dalits we cannot live. We are landholders. We want workers for the fields. Without them we cannot cultivate or take care of our cattle. But dalit women's relations with other men are not out of economic dependency. She wants it from him. He permits it. (Human Rights Watch 1999: 31)

IN CONCLUSION

Writing quite innocently about the communalization of population in India several years ago, I was utterly astonished, indeed frightened—which, I suspect was the intention—by the responses I received, in the form of

many, many postcards. I was labeled anti-Hindu, and many of the writers hoped that I would move to Pakistan, where they said my wife would get raped. A decade later websites run by Non-Resident Indians in the USA, anxious about their Hindu-ness, while they had forsaken their country, repeated similar venom. This too could be inexplicable, indeed un-thinkable: here are the self-proclaimed best and brightest, at the acme of their professional careers in the land of milk and honey, writing what can only be described as pornography.

How does one explain this? What this chapter has attempted to do is to understand how ideas of population, of neo-Malthusianism, are re-configured, re-constructed, and molded by other ideas, of race, of gender, of community, and indeed nationhood. It does not seem to matter at all that neo-Malthusian ideas are repeatedly shown to be historically and empirically shallow. They bafflingly gild many disconnected discourses, giving the politics of numbers contemporary bite and pungency.

The novelist Julian Barnes, similarly baffled by the appeal of Thatcher, notes that her achievements were truly remarkable. She revealed that it was possible at times to do the truly unthinkable. She taught us that:

> You could survive while allowing unemployment to rise to levels previously thought politically untenable. You could politicize hitherto unpolitical public bodies, and force the holy principles of the market into areas of society presumed sacrosanct. You could sharply diminish union power and increase employer power . . . You could make the rich richer and the poor poorer until you had restored the gap that existed at the end of the last century . . . You could do all this and in the process traumatize the opposition . . . and even manage to get votes from the unemployed. (Barnes 1999: 546)

How did she manage this? One, alas all too banal way was, of course, by appeals to demagoguery and chauvinism. The second was what Barnes calls the "gut appeal to nature". But, of course, a nature modeled on capitalism, of nature red in tooth and claw, much as Darwin did with talk of the survival of the fittest.[18] Thus, natural is constructed to mean the celebration of supreme and un-curtailed self-interest of the rich, and competitiveness in society.

If nature was indeed this way, who were we to intervene? Perhaps it is hubris to intervene? Nature, in other words, appears to tell the listener that the poor and other victims of the system are merely reaping what they sow,

just as the rich and the privileged do. What Thatcher did, much as Malthus did before her, was to argue that the poor had no moral right to welfare. What she also did was to reduce the enormous complexities of social life to simple homilies, replacing hesitation and questioning with granitic certitudes set in cold stone. In short, the success of neo-Malthusianism depends on the reduction of unpredictabilities, of uncertainties of life, and of the political with the hard givens of Malthusian arithmetic, thus depoliticizing politics. The success is precisely in naturalizing the social and therefore the contingent, giving it a timelessness, a timelessness as fragile as anything carved on stone.

As the new wave of globalization sharpens inequalities, accentuates the rate of exploitation, and as the dispossession of the poor globally increases the transfer of resources from the poor to the rich countries, neo-Malthusian discourses serve to naturalize these processes. At the same time it provides "natural" explanations for sharp political conflicts over resources, natural, social, and intellectual. Fundamentalisms, anti-feminisms, and racisms are congealed into this.

ACKNOWLEDGMENTS

NOTES

1. "Most Americans Want Immigration Drastically Reduced" reads a full-page advertisement in *Harper's* of October 2004 (Vol. 309, No. 1853: 19), put forth by negative population growth. It goes on to argue about the "catastrophic effect of overpopulation on our environment, resources, and standard of living". Neo-Malthusian underpinnings are evident in some of the security discourses on refugees, and are at the heart of dominant global discourses on the environment. We only need to remember that as soon as elections are announced in the UK, immigration becomes an issue, not just for the Conservatives, but also for the New Labour. At the same time, a sub-discipline of

"strategic demography" has emerged, that seeks to locate the growth of Islamic fundamentalism in the "youth bulge theory", that is, that population growth in Islamic countries, characterized by a high proportion of youth, spells political hazards, not just to democracy in their own countries but to the so-called free world (See Hendrixson 2004). This does not explain the rise to dominance of fundamentalism in the United States, which of course has no youth bulge, but such matters of truth or rigor rarely troubled demographic discourses in the past, and obviously do not, today. In other words, the population growth argument remains compelling, and truly protean, explaining just about everything, and thus explaining nothing.

2. Created by the 73rd Amendment to the Constitution, the PRIs are the lowest level of elected public institutions responsible for self-governance. Reservation of a proportion of seats for women and deprived communities in these bodies is seen as an important means to empower them, involve them in decisions that affect their lives. Yet, clearly, the fertility norm imposes restrictions on this empowerment.

3. Madhya Pradesh rescinded this law last year (2006). But this was not because of Cairo winds blowing late over MP. The chief minister argued that they would re-introduce this law again in the state when Parliament passes such a law to cover all elected posts in the country. Since the state is ruled by the BJP, the withdrawal of this law is probably more due to the Hindu right-wing's anxiety about numbers, rather than a respect of democratic rights, including reproductive rights.

4. Two of them, one named the Population Stabilisation Bill 1999, and the other, the Population Control Bill 2000, for instance, moot the idea of a one-child norm along with a number of incentives and disincentives, including disqualification of persons with more than one child from contesting elections. Yet another bill, the Bachelor's Allowance Bill 2000, suggests incentives to those men who remain bachelors. Men, who, taking advantage of the incentives, subsequently get married, are to be fined and imprisoned. Yet another bill, the Population Control Bill 2000, also seeks to punish people who violate the small family norm with rigorous imprisonment for a term of five years and a fine, not less than Rs. 50,000. The Population Control and Family Welfare Bill 1999, proposes in addition to incentives and disincentives, the compulsory sterilization of every married couple having two or more living children.

5. Often the same organizations, today arguing for reproductive health and rights, were involved in creating the population explosion concept. They have the same attached academics and NGOs. Recently, of course, their numbers—and reach—have dramatically increased, in response to increasing NGO-ization of the health system, most often in response to donor/lender demands. What needs to be sufficiently explored, and it hasn't, is why and how these donor/lender agencies command so much clout, given their relatively small contribution to India's health budget.

6. Rudyard Kipling, written in 1899. "The White Man's Burden"

> Take up the White Man's burden
> Send forth the best ye breed
> Go bind your sons to exile
> To serve your captives' need;
> To wait in heavy harness,

On fluttered folk and wild
Your new-caught, sullen peoples,
Half-devil and half-child.

7. These tropes hang heavy and loom over neo-Malthusian discourses in contemporary times, when we are enveloped in the second wave of globalization.

8. For how eugenic ideas, fused with Evangelical Christanity, about the Other influenced. The USA soldiers in their many wars in South America, see Grandin (2006).

9. The RSS is a secretive Hindu fascist organization that calls itself a cultural body, seeking to transform India into a Hindu theocratic nation. Founded in 1925, it is modeled on the lines of Mussolini's Brown Shirts. The parliamentry party, the Bharatiya Janata Party (BJP) is its "moderate" face. It also spawns a number of more militant organizations such as the Vishwa Hindu Parishad. See Basu et al. (1993).

10. For a critique of this concept, and how they are framed by both colonialism and imperialism, see Mamdani (2001).

11. Anand Patwardhan's documentary "The Father, Son and Holy Ghost" explores this theme with its trenchant—and sharp—documentation of the Hindu right-wing's project.

12. Mamdani notes the ease with which overpopulation arguments were used to explain the genocide in Rwanda, even as he shows how the colonial constructions of race, carried over into post-colonial institutionalization of citizenship, were both powerful factors in the genocide at Rwanda, but to carry this out, the victims were first to be denied humanity (Mamdani 2001). Grandin shows us that the much earlier genocide in Latin America, indeed the genocides in the Americas, was possible only because Indians were deemed not human, not fit for redemption into humanity (Grandin 2006).

13. Curiously enough, Sidney Webb wrote his tract *The Decline of the Birth Rate* at about the same time. He was concerned about the "race suicide" in England as the population of England was becoming increasingly Jewish and Irish (Jayal 1987). The Webbs, Wells, and Shaw were all fervent believers in eugenics.

14. It is interesting that it was the semiotics of this image that was conjured up by some women members of the BJP, protesting the possibility of Sonia Gandhi exercising her citizenship rights to the Prime Ministership of the country. These MPs threatened to tonsure their heads if Ms Gandhi was elected the PM. A tonsured head is, of course, the sign of an upper caste widow in Hindu society. The matter, they argued, was not of rights and the Constitution, but Hindu emotion that over-rode these rights. Thus is wedded anti-feminism to communalism, with women BJP members making a patriarchal bargain. While the appeal was, of course, to timeless traditions and culture, albeit only the upper-caste ones, what was being fought over was much more quotidian.

15. The PTI reported from Rohtak on December 29 that the VHP president Ashok Singhal said Hindus should give up family planning so that their population does not go down. Speaking at the inaugural session of VHP's joint meeting of the international board of trustees and the central management committee, he said population of minorities, especially Muslims, had been rising at "such a fast pace" that it would be 25 to 30 percent of the total population in 50 years. Singhal said it would be "suicidal" for Hindus if they did not raise their population. He said that it was essential to build a Ram temple at Ayodhya for "*dharmik azadi*" (religious freedom) of the Hindus. Further, at

the Margadarshak Mandal, its apex body meeting in February 2005, a resolution was passed calling upon Hindus to follow the ideal family size set by Lord Krishna's parents and "contribute constructively towards increasing the Hindu population" (*The Statesman* 2005). The resolution also called for checking Bangladeshi infiltration and preventing Hindu girls from marrying Muslim boys. Krishna, the resolution pointed, out was the eighth child of his parents as was Netaji Bose and Rabindranath Tagore, the ninth!

16. This sentence is riddled with minefields, defeating his own argument, since he notes that non-vegetarian Parsees also had low birth rates. Nevertheless there is a curious and entirely incorrect characterization of Brahmins as strictly vegetarian. Indeed the Brahmins of Kashmir, who consider themselves the Brahmins of Brahmins, are non-vegetarians, as also the Brahmins of Bengal and South Kanara. But today, at the height of Hindutvavadi resurgence, it is being asserted that all Hindus are essentially vegetarian in a move to deny beef to the Dalit and Muslim communities.

17. This indeed was Mahatma Gandhi's position on birth control.

18. Tennyson might be taking somersault in his grave if he knew how his famous line "Nature red in truth and claw" inspired not just Thatcher and the Bushes, *pere* and *fils*, but also the Hindu Right and the Islamic Brotherhood and indeed all those who favor the current neo-liberal world order!

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6

Neo-liberal Development and Reproductive Health in India: The Making of the Personal and the Political*

Rachel Simon-Kumar

INTRODUCTION

In the decade since the International Conference on Population and Development held at Cairo in 1994 (ICPD), feminist writings have highlighted neo-liberalism[1] as a dominant force that poses a challenge to a reproductive health approach[2] to population policies. Research examining the implications of neo-liberal policies on reproductive health outcomes has provided a variety of conclusions. Some authors (Petchesky 2003; Standing 2000) argue that neo-liberal agendas, which are manifest in health sector reforms, cost recovery/user payee plans, individualization of health responsibilities, and consumerist trends in the delivery of health, are practices that are impediments to reproductive health policy. Yet others (for example, Smyth 1998) argue that the increased emphasis on efficiency, quality of services, and accountability of public health systems enhance women's opportunities for better choices and care. In the latter view, the ideological foundations of these services—whether neo-liberal or otherwise—are immaterial because they ultimately, and in some form, do provide tangible improvements to women's health outcomes.

It is, however, in considering empowerment outcomes for women that the compatibility and/or incongruence between these two paradigms become apparent. When the discourses of reproductive health were gaining international attention in the 1980s and 1990s, the changes envisioned through women-centered population policies were intended to include better health outcomes (improved care and services) as well as a range of rights: namely, individual rights (such as control over one's body, and decisions about personal reproduction), and collective improvements for women (better claims to political empowerment). Yet, research during the same decade has pointed out that women have been worse off in many walks of economic and social life under the regime of neo-liberalism—in particular, "rights" and "empowerment" of women, in many respects, have been seriously compromised.

This backdrop of a paradigmatic incongruence between neo-liberalism and reproductive health approaches poses the key question raised in this chapter—*can neo-liberal states set up transformative conditions for women that can advance their reproductive interests politically?* To debate this question, this chapter focuses on the relationship between women and the contemporary neo-liberal state. It interrogates how the politics of empowerment is a reflection of the construction of what is "public" (with attendant understandings of "agency" and "empowerment") in market-led development states. Using the tools of feminist post-structuralist analysis, the chapter explores representations, meanings, and ideologies that surround the conceptualization of gender in reproductive health policy. How are women represented in neo-liberal development states? What are the meanings attached to reproductive activities? Are these identities empowering in a "public" space influenced by ideologies of the free-market?

This chapter is divided into two parts: the first draws together conceptual/theoretical strands developing the linkages between women, neo-liberal states, and reproduction. The second part focuses on India. The 1990s in India have seen dramatic shifts both in population policy and economic policy, the impacts of which are yet to be fully understood and evaluated. The family welfare program has been ostensibly moving toward a comprehensive and integrated reproductive health program with a focus on gender sensitivity, while the state has been enacting liberalization and market-friendly policies in economic and social policy. Drawing on

the context of reproductive health policy in India, the latter part of this chapter will attempt to outline the contours of the relationship between women, reproduction, and neo-liberalism in developing societies in the 21st century.

<div align="center">I</div>

THEORETICAL LINKS: WHAT IS "NEO-LIBERALISM"?

Neo-liberalism is a strand of economic thought, which has gained world-wide ascendancy since the 1980s (although its origins can be traced to economic writings of Adam Smith in the 18th century, and indeed even earlier to the Physiocrats and their ideas of *laissez nous faire*). Its foundations are built on the belief that markets should be allowed to work unrestrained in order for economies and societies to reach their full potential. The idea of the "free market" or "liberal economy" has been a volatile concept in the last three decades; its supporters argue that with the removal of all forms of barriers to expand economic activity, economic growth is unquestioned and public good assured. Those opposed to the idea of neo-liberal forms of markets have highlighted the fallacy of the notion of "freedom"; free markets perpetuate income inequalities and are responsible for lowered quality of life for masses of people that is often at the cost of political freedoms. In particular, the part or full removal of the state from the everyday social concerns of its people (as in, for instance, the provisions of health, education, and social security) has raised questions about relationships between citizenry and the nation-state, and the responsibilities within the public sphere (which is perceived as being governed by the state) and the private sphere, which is the domain of the private individual or household. We shall return to this latter point about the public–private below as it raises key issues for women's rights and self-determination.

In order to understand the political context created by neo-liberalism, it is important to examine the sets of relationships that neo-liberalism creates between individuals and institutions: namely, citizen, society, the market, and the state. By encouraging policies and institutional structures based on the principles of de-regulated markets, states that have adopted neo-liberal development patterns have radically challenged beliefs about the

ways in which individuals and key economic, social and political insti-
tutions relate to each other. These relationships form the basis for rights and
entitlements, and the marking of what is personal and what is political.

Observers and critics (Needham 2003; Yeatman 1997) of neo-
liberal development strategies across countries note some of the common
themes defining state–citizen relationships in the past two decades or so.
Most dominantly, there is an explicit rhetoric around contractualism and
that citizens cannot expect the state to take care of all their needs. The era
of subsidized public goods and social welfare support from the state is
all but completely eroded. States are increasingly becoming one among a
range of providers of social services and goods, and citizens are learning
to purchase these goods rather than expect them as part of the entitlements
of citizenship. Further, individuals are increasingly informed that they are
responsible for their own well-being. So, whether it is old age security,
health, or education, individuals must find the resources to take care of
their own needs. In this way, individuals are deemed creators of their
own prosperity. Poverty, consequently, is often deemed an outcome of indi-
vidual shortcomings rather than a reflection of systemic inequalities.
Alongside, the notion of citizenship is measured by economic productivity,
that is, in order to be a "productive" member of society, citizens must
in some way establish that they are contributing to the growth of the
society. Often, this is through participating in the labor market. In the neo-
liberal view, a good citizen is ontologically an active participant in the
labor market.

Under neo-liberalism, the notions of "public", "public services", and
"public good" are fast changing. Whereas a dominant development trope
of the 1960s and 1970s was investment in human capital because it was
seen as beneficial to society as a whole in the present and for the future,
there are less clear ideas about what forms of investment (whether eco-
nomic, infrastructure, financial, or people) best benefit society as a whole
and who—whether it be the state or the private sector—should be driving
these investments. The privatization of infrastructure industries, prison
services, aspects of defence, and so on, destabilize traditionally held
ideas about what is governed by the nation-state (the polity), and what
is influenced by commerce (the market). Public and private spheres are
less clearly demarcated.

Finally, critics also point to how citizens are increasingly turning
into "consumers" and clients of the state. The neo-liberal state promises
efficiency and effectiveness in its delivery of services to citizens. In so

doing, it emphasizes a "managerial" criteria of quality as if the state is one of several agencies providing services to the people. The state's role in undertaking social services is not defined by issues of equity and social transformation as much as by values of corporatism. In turn, the "rights" of a citizen are fast being displaced by the rights of a consumer.

For nation-states that had full-fledged social welfare programs in place through the 1960s and 1970s, the imagery of the "cradle to grave", and "parental" state caring of its citizens was fast replaced from the 1980s onwards by symbolisms of the state as a steward and an administrator of resources whose obligations were bound mainly to prudent management. If there was ever a change in imagery from a maternal nation-state to a cold, detached "masculine" inhuman machinery, neo-liberalism was influential in the production of this symbolism.[3]

It must be noted that the development of neo-liberalism itself has also been through some revisioning. In the 1980s, neo-liberal discourses constructed the state as antithetical, for the most part, to the interests of the market and consequently, its sphere of influence was to be diminished as much as possible. By the mid-1990s, there was a gradual shift, within neo-liberal thought and practice, to include the state once again within the ambit of development. There was an emphasis on "governance" structures as an evolving part of neo-liberal development, the argument being that economic growth could be assured only when robust political frameworks existed alongside a sound economy. Often referred to as the "Third Way" or the social investment state (Giddens 1998), this revisioning of neo-liberalism has opened the way for a new role for the state and a new charter for its citizens. Through the language and practices of contemporary social policy, which encourages "participation", "partnership", and "engagement", the "citizen" has been recentered—in principle, at least—in discourses of statehood and development.

GENDER AND CITIZENSHIP

The ideas around relationships between citizens and states that accompanied the advent of neo-liberalism have specific gender ramifications. This is largely because, as feminist commentators point out, women as "individuals" or "citizens" within the state have always had entitlements and rights that are different from the "main/male" stream differences that are accentuated by the context of neo-liberalism. Attempts to

explain this essential difference have taken scholars to the foundations of citizenship and political theory, and drawn out how women are constructed in the public and personal spheres. Within the fundamental political thought of Western liberal democracies,[4] social spaces, both literally and metaphorically, were separated into "public" and "private" spheres. Women were, by default, beings of the private sphere because they had a "natural" flair for reproductive work. Their encounter with the public world was through their identity as a supporting cast for the men who were the main characters in the politically-relevant spaces of the public sphere.

That women inhabited different spaces from men meant that they had differential relationships as citizens. Men's relationship with the state had a direct political basis as they were seen as individuals and as representatives of the family, while women did not enjoy a similar status. The main reason for the differential positioning of men and women in relation to the state has been traced to the status they hold in the public and private spheres. Men were perceived to have capabilities that are exchangeable for political rights, and it was usually these capabilities that formed the criteria for citizenship. For instance, a dominant construction of citizenship is around military service—the image of the "citizen-soldier-protector" is quite strong in many societies as that of an "ideal" citizen. What is important is that in many societies this is a male-defined construction. Women's relationship to the state, in contrast, tends to be much less direct. Women have the capacity to produce future soldiers for the country, be caregivers for future and past generations (Pateman 1988). In many societies, they are presented as symbols of "authentic" cultural and national identity, preservers of the purity of lineage. Often, these are images that are an extension of their role in the "private" spaces, as virtuous wife, sacrificing mother, and so on. Their reproductive identity incarcerates women into a less-than-direct relationship with the state; as a result, women tend to be seen as secondary citizens of the state. It is not surprising that issues related to women's rights as citizens—the claims that they can make of the state—are not as easy to justify.

Understandably, establishing a sense of primary citizenship with the state has been fundamental to feminist struggles for equality and equity.[5] From as early as the 18th century, women have argued for inclusion in the public space on merits comparable to those of men. Thus, they argued for rights to vote, increased political participation, employment, education,

and so on. The aim of these efforts was to alter women's existing relationship with the "state"—seen at that time as the seat of political power and status.

While a strand of feminism (the liberal feminists[6]) continues to advocate these means to improve political conditions for women, there is an increasing recognition that the relationship between the public space and women's rights is far more complex than acquiring masculine attributes to trade off against the state. Two realities, in particular, led to a more critical feminist perspective of the public space. The first was the shifting meanings attributed to the public space. Within feminist movements (across the globe) there were changing understandings of the markers of what constituted *rights* for women. Whereas the early feminists defined rights in relation to a male-defined public space, the rise of the second wave of feminism in the 1960s/1970s saw an increased focus on the political significance of the private sphere. Feminists argued that most of women's activities and indeed, the violations committed upon women, were often in the private sphere; consequently, rights and empowerment came into focus when the spotlight was thrown on the unspoken, unseen, and unheard. It was in highlighting the "personal" that the "political" was to be gained.

Both these views on the public/private and the political—that entry into the public sphere signifies political power and that it is in revealing the private that full rights are attained—have been questioned even further by feminists of the 1990s. Feminist writings (such as those of Benhabib 1998; Brown 1992; Landes 1998) argue that contrary to received wisdom, the public space does not represent political rights for women. If anything, visibility within the public sphere is likely to increase the monitoring, surveillance, and regulation of women's identities. The experiences of women in relation to the Western welfare state, in particular, has been significant in the emerging critique that the state re-draws private/public boundaries as part of a complex regulatory strategy to advance masculinist ideologies. In other words, rather than encouraging "rights" and "empowerment", the contemporary public space has the potential to denude women of power by constructing particular meanings of what is appropriate for women. The symbolisms projected about women are considered more pertinent than whether they are *in* the public space.

A second reality was the recognition among feminists of the changing relevance of institutions within the "public space". In the early theorizations

of feminism, the state was seen as the seat of power, and identities of citizens revolved around nation-building. By the 19th century, however, the state was steadily losing ground to the primacy of the market. The market was "increasingly the reference point for defining the public/private split", in which the public (the market) was privileged. Jennings (1993: 122) succinctly captures this point, ". . . the prominence of the 'economic man' is an artefact originating in nineteenth century cultural interpretations, which conflated man with dynamic market activity and woman with unchanging familial roles". A new definition of women as non-economic beings emerged, and this was more critical to the interpretation of their identity in society, whereas their former definition as non-political beings was no longer essential to that interpretation. The shift of political identity toward economic value could explain why women were able to win political rights (like the right to vote) since the 19th century rather than economic rights. Therefore, the development of the market went hand-in-hand with a definition of women's political identity that was tied to their perceived economic value. In a neo-liberal state, the shift from a "citizen-mother" to a "citizen-worker" has particular implications for relationships between state and citizen.

These two key ideas—that productive capability defines citizenship *and* that public spaces can be arenas of control rather than emancipation—are fundamental to the neo-liberal constructions of gender in the 20th and early 21st century. The rest of this chapter develops this fundamental theoretical premise to ask: how do these theories around relationships between individual and state apply to "Third World" women (particularly, in India)? What relevance do these ideas have for reproduction/reproductive health?

GENDER IDENTITY IN DEVELOPMENT

Not unlike the "West", gender identity in "Third World" societies has also been predicated around ideas of "public" and "productive". From the early writings of Women in Development (WID), the development "space" was tacitly divided into public and private spheres, and women's relationship to these spheres developed within evolving theoretical frameworks. When the women in development theory emerged in the 1970s, the built-in

assumption was that "development" was occurring in a space that eluded women's free and fair entry, that they were "out" and men were "in".

Development, at the time, was dominated by the modernization thesis that set up aspirations for Third World states to become like First World developed nations. The ideas of public and private were subtly embedded in these aspirations. Third World peoples were encouraged away from a "traditional" way of life to a "modern" one, from the rural to the urban, and from ignorance to skill and technological adeptness (Scott 1996). Modernization theorists saw the public realm as aligned with the symbols of modernity: industrialization, urbanization, progress, governance by a state and bureaucracy, and essentially, the economic sphere of the market. The private realm was the tradition-bound village, dominated by the structures and values of the family and the household. Not surprisingly, the development theme was strongly gendered: the public realm had been populated by the men who left their villages to participate in the modern life of the urban area while women remained in the traditional "private" reproductive sphere. Quite similar to the 18th century feminists who argued for women's entry into the public space, early WID critiques in the 1970s led by Ester Boserup pointed out that women were being excluded from the processes and fruits of development. Development writings on behalf of women in the Third World charged policymakers for being "blind" to the economic and pro-ductive contributions of women and strongly argued that women's eco-nomic and social status was largely deteriorating because their labor was not accounted for under the modernized economy of the public realm. WID efforts had been, and often still continue, to emphasize women's contribution to economic production and to integrate Third World women better into mainstream development processes as a precursory step to empowerment. A dominant tendency in WID writings was to equate the "development process" with the "productive sphere" or monetized market processes and argue that women's social and political relationship to key institutions of power (such as their own households, power structures in local communities, the state, and the market) would shift as a consequence of their involvement in this sphere.

The calls for moving women into the "public sphere" of development— be it the labor market or commodity market—resonated at various levels of development scholarship. Amartya Sen (1990), for example,

makes this point in his writings about the household; he emphasizes that women's bargaining power within private transactions will be enhanced by the perceived worth of their entitlements. Their entitlements, in turn, would be directly reflected in women's potential to exchange their labor power for earnings outside the household, in the realm of the productive economy. Authors like Miller (1981) equate the public/productive sphere to rural agricultural labor. She attributes the prevailing lower social status of female children in northern India, where women have traditionally not been part of the dry-cultivation agricultural workforce, to their future lower earning power. In contrast, women in Southern India who have traditionally predominated in wet-farming cultivation of crops like rice have better intra-household status. International donor agencies also emphasize economic identity as a step to gaining political recognition. The World Bank (1991: xvi), also refers to the "inside/outside" spaces and postulates that it is through engagement in the "outside spaces" that women will begin to command a fairer position in society.

The emphasis on encouraging women to participate in "productive" activity is not without critique. There is enough empirical evidence to show that locating women within market processes does not automatically guarantee beneficial political identities; in fact, quite often, it is the market that denudes women of any sense of political empowerment. Repeatedly it has been argued that the market system—the sphere of economic productivity—has disempowered women. For women, being in the workforce often only adds the stresses of double and triple days (additional burdens from working outside and within the home). Also, in shifting to a monetized economy, women are subject to perceptual biases about what work they can do, the kind of laborers they are (docile and easy to manage) and face discrimination within segmented labor markets. The stereotyping of women as predominantly home-makers is used to devalue their work and keep their wages down. At a global level, as has been well documented, such perceptions create the dehumanizing conditions for work in export-oriented industries run by multinational companies. These critiques of the market extend to the neo-liberal strategies that have had gender effects beyond the realm of the labor force. The neo-liberal state (particularly, the minimalist neo-liberal state of the 1980s) depended on women's unpaid labor (especially in the care economy of dependents and community work) to take on the activities that it no longer funded through

its social welfare programs. Moreover, research for over two decades has shown how the removal of food, health, and education subsidies has affected women in ways different from ways they have affected men. Left to the designs of the "free market", women are worse off than men given the gender biases that influence their everyday realities.

Critiques of the market notwithstanding, contemporary neo-liberal development practices and conceptualizations have centralized rather than distanced the market as a determinant of empowerment outcomes for women in the Third World. It is important to note that the "market" here is depicted both as an institution and a set of values/ideologies. Thus, in writings about women's empowerment, participation in market activities is still viewed as a dominant force against the influence of patriarchy in the private/domestic sphere. The "natural" allocations of the market, it is believed, are based on merit and would give to each individual (men and women) their due of their claims to political rights. Indeed, the "free-market", it is postulated, has better opportunities to be free of gender anomalies and is better suited to empower women. This view also strongly advocates *against* turning to the state for political rights; after all, the neo-liberal state in its "minimal" role can offer little recompense, especially to women. Rather productive capability, a versatile range of skills, and participation and flexibility within the labor market are the new attributes of a good citizen. Feminists, however, are concerned that the gender sub-text of this view is often ignored; scholars such as Brodie (1994) argue that by giving primacy to market institutions and the negation of the state, there is compelling indication that women's interests are being reshuffled and banished to the realm of the "private" sector. This, in turn, is a space where conservative forces dominate over women's interests.

In the late 1990s, the state has re-entered the debates on development, both notionally and in practice. But these debates continue to embrace the market as the guiding principle for relationships between citizen and state. The language of efficiency, effectiveness, and quality services have conflated the ideologies of the market and the state. Taylor/DAWN (2000) refers to the "marketization of the state" where the state is not counterpoised to the market but, rather, has become the market. Consequently, there is constant incursion of the social into individual lives (as in the onslaught of commercial, military, and ideological forces on people's everyday lives). Here, the concern for feminists is not that

the space of political rights (that is, the state) is receding, but that the distinctions between the "public", "private", "the individual", and "the social/economic" are fast blurring. Feminists are concerned that notionally the "public" are becoming less a place for agency and rights; rather it is becoming a space where citizens are being converted into ideological subjects. Citizens are given the message that their relationship with the state is less about what "rights" they can claim from the state than what "obligations/responsibilities" they owe the state.

Thus, in development contexts—just as much as in "Western" ones—the relationship between the state and market, on the one hand, and between the state and women as citizens on the other is greatly dependent on the underlying nature of the public space and the characterization of "productive" identities. The private or the public "space" on its own does not indicate rights. There is a complex interplay between identities (of citizenship-woman) and the context of public–private/state–market. One of the difficult points that we confront is the lack of any formulaic alignment of identities and entities that can serve as a model that would guarantee rights in a neo-liberal setting. Certainly there are diverse propositions about how best women can improve their status as claimants to political rights; in some cases, it is by activating the state and in others, it is in the market. These options, however, must be analyzed against the context that determines the relationships and identities, symbolic meanings, the force of discourse, and the possibilities of interpretation that actors in a political field are able to command.

REPRODUCTION AND POLITICAL SPACES

It is time to bring the focus in this chapter back to reproductive health and neo-liberalism and tie it in with arguments around productive identities and political spaces that have been developed so far. In conventional arguments about public and private spheres, "reproduction", "reproductive activities", and "reproductive identities" are conventionally positioned as being of the private sphere. Women were explicitly disadvantaged because of the association of reproductive activities with the private sphere. In fact, it was women's natural role in reproduction that caused them to be considered "non-productive" and, often, second-class citizens.

An unpacking of the relationship between "reproduction" and "public/private" spaces, however, suggests that the accepted convention is perhaps not as precise as is made out. To understand some of the nuances of this relationship, it is important to distinguish between social and biological reproduction; the former refers to care activities of dependents and communities undertaken by women and the latter to issues of fertility and childbirth. With regard to social reproduction, as was mentioned earlier, certainly there has been a move under neo-liberal policies to "re-privatize" care activities that had been supported by state programs under welfarism. That is to say, these activities were being removed/excluded from the priorities of the public space because they are not seen as vital economic activities that are crucial to market priorities. This has meant an increased burden on individuals (often, women) and households to meet the needs of childcare, care of the aged, sick, support to community work, and so on.

It is the manner in which biological reproduction and fertility is constructed in the public/private sphere, however, that is of interest here as it is these constructions that underpin population and reproductive health programs. Biological reproduction has elicited a different response from neo-liberalism when compared to social reproduction. Gallin (1998: 16) suggests that, contrary to the widespread view that reproductive activities are unimportant and, therefore, marginalized in neo-liberal states, the "control of women's reproductive powers is crucial to the maintenance of the global economy . . . [T]he imperatives of this economy demand that women (and men) adjust so that they can *produce and reproduce* efficiently". Biological reproduction of labor power is crucial to capitalism and the various discourses of size and quality of the population, pro-natal/anti-natal, and controls on who can and should reproduce are all manifestations of an ideology that aims to create a labor force that meets the exigencies of contemporary capitalism. For Gallin (ibid.) the "mode of reproduction may be separate from the mode of production but it is regulated by the logic of accumulation".

It is, then, perhaps not surprising that neo-liberal reforms in the "West" in the 1980s were accompanied by a strong wave of conservatism around ideas of the family and sexuality. Restructuring in Britain during Prime Minister Thatcher's time was replete with propaganda to reinstate the idea/l of the family, not just in family size but in composition as well.

Politics was deeply concerned by the social "problems" of illegitimate births, divorce, single motherhood, teenage pregnancies, and loss of the traditional concept of family. There were also discourses around the regulation of reproduction by immigrants. Quite easily, then, neo-liberalism was enmeshed in debates on eugenics, heterosexuality, racism, and antifeminist fundamentalism. Gallin's (1998) argument is that the state's concern is not just about reducing the "size" of the population that it has to support; it is equally interested in the "quality" or the eugenicist concern with selective breeding of the population. As she argues, the aim of population policy (be it pronatalist, anti-natalist, or immigration policies) is to construct a labor force that meets the exigencies of contemporary capitalism. The conduct of women's reproductive activity has economic value and is vital to the state's neo-liberal economic agenda.

In developing or Third World societies, the institution of neo-liberal development policies has served to re-establish a long-held association with neo-Malthusianism, highlighting the assumptions that many demographers postulate between constraints to economic growth as a consequence of large population sizes. Neo-Malthusianism and neo-liberalism became immediate allies and the practice of neo-liberal policies has grown alongside the rhetoric of restraint in population growth. The overlap between neo-liberalism and neo-Malthusianism, in some instances, is *deliberate* as in the case of SAPs in African economies that were instituted with clauses about population control. For example, the *Enhanced Structural Adjustment Facility Policy Framework Paper* for Gambia (1998–2000) put out by the International Monetary Fund (IMF) states that "reducing population growth rate" and "promoting family planning" are two of the objectives[7] of the stabilization policy in that country. Similar population goals were embedded in the SAPs of other African states as well.

In other countries, the overlap between neo-liberalism and neo-Malthusianism was seemingly *incidental*. India is a case in point. The New Economic Policies (NEP), India's initiation into the liberal economic agenda, began in 1991 with no overt emphasis on population issues. Yet, by happenstance or by design—as will be elaborated in the next section—the "events" of neo-liberalism and neo-Malthusianism have not been far apart. Consequently, the emerging relationships between the neo-liberal state and women reflect the particular complexities of contemporary politics

in relation to reproductive health issues in India: women's empowerment is wedged between market-influenced economic policy and ongoing discourses and practices of a population control program.

<div align="center">II</div>

THE CASE OF INDIA: REPRODUCTIVE HEALTH POLICY IN THE 1990s—AN OVERVIEW

India's family planning program began in 1951 as a voluntary program for couples desiring to know more about contraception but in the half-a-century since then the program has gone through a challenging, if not controversial, history. At the time of the ICPD in 1994, the family welfare program in India was strongly anti-natalist; although it was not coercive as it had been in the 1970s, through an array of incentive and disincentive strategies, the program aimed to gain support for a maximum family size of two children with a difference of two years between them. The program emphasized female sterilization to achieve this family size and recommended a limited number of temporary contraceptive measures to "space" out births. The program was guided by the goals set out in the National Health Policy (1983) which was to achieve a net replacement rate of one by 2000. It also aimed to strengthen child health, reduce morbidity and mortality in women and children, and safe motherhood services.

Most of the family planning services in India at the time of the ICPD were provided by the public sector with non-government organizations (such as the Family Planning Association of India) providing some services in a few urban centers. There was also some social marketing and retail sales of contraceptives, mainly oral contraceptives and condoms. Abortion services were available in the public and private sectors, with the former provided freely under the conditions of the Medical Termination of Pregnancy (MTP) Act. By the early 1990s, it was becoming clear that the family welfare system was not delivering the demographic outcomes that had been projected (at least in terms of fertility). A series of reviews undertaken to comment on the state of the family welfare program in India identified a need to respond to systemic problems in the family welfare system itself, namely, improving the quality and outreach of family welfare

services, modifying the system of targets and incentives, and devolving more responsibility to the states (Government of India 1992). There were also proposals to link the program better with women's empowerment by increasing opportunities for women to participate in paid work (see the comments on the Report of the M.S. Swaminathan Committee in Merrick 1996). Consequently, in response to these concerns and signaling India's commitment to the ICPD process, the following key strategies were introduced in the program:

The Target Free Approach (TFA)

In 1995, a decision was made to eliminate the state's practice of enforcing numerical targets that had been adopted in the mid-1960s. Numerical targets for each state were fixed by the central government (often arbitrarily) and these were passed on to state governments, districts, and community level centers to be achieved annually. The system of targets has been widely criticized on human rights' grounds and seen as a key factor in encouraging poor service. The TFA was first introduced in one or two districts of Kerala and Tamil Nadu. A year later, in April 1996, the government declared the entire country as target free. The TFA also included dismantling incentives for health workers; practices such as provider and motivator incentives were scrapped.

The Reproductive and Child Health Program (RCH)

Alongside the TFA, the Government of India also launched the Reproductive and Child Health Programme (RCH). The program was formally launched in 1997 and was intended to replace the existing family welfare program. The aim of the RCH is to provide integrated and comprehensive reproductive health services of high quality to meet the satisfaction of "clients", that is, the users of the family planning services. The integrated package of services includes family planning, child health services, safe motherhood, and addressing reproductive morbidity such as reproductive tract infections and sexually transmitted diseases.

The National Population Policy (2000)

A third shift in the population policy landscape in India was the National Population Policy (NPP), which forms the current basis of the population

policy in India, and mirrors India's commitment to an empowerment-focused approach. The immediate objectives of NPP 2000 are to address unmet needs in the areas of contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The policy aims to achieve a medium-term goal of bringing TFR (the total fertility rate) to replacement levels by 2010. The NPP lists significant demographic goals such as the total fertility rate lowering of infant and maternal mortality, and containment of AIDS/HIV. However, following the ethos of the RCH and the TFA, the NPP also advocates promoting high quality, comprehensive, informed family planning infrastructure and services that would enhance people's access to information and choices. This package of responses by the Government of India was unlike any previous family welfare service. In fact, the changes in the family planning program were called a "paradigm shift" in recognition of the fundamental changes that the program was seeking to bring about.

Certain features marked the changed policy of the 1990s. The first was the greater role given to individuals and communities. A repeated theme in the RCH, TFA, and the NPP was the centrality of the "user" in aspects of planning, implementing, and deciding to use the state's services. Erstwhile "recipients" or "beneficiaries" of the family welfare program were now called "clients". Documents of the RCH state, for instance, that the family welfare system will take a "client-centered approach to service provision" so that there is "client-choice" and that "client needs" are met. The "community" also assumed a greater role. The 72nd and 73rd Amendment to the Constitution enhancing decentralization by law brought the family welfare program within the ambit of local bodies. RCH documents emphasize the role of local communities stating that "the shift in the philosophy calls for community participation in planning, implementing, and monitoring so as to make it a 'people's programme'" (Government of India 1997a: 1). Despite the reshuffling and re-packaging of the programs, the theme of community participation appears to continue. For instance, in 1996, the TFA was modified to Decentralized Participatory Planning (DPP). In 1998, the DPP was changed again to become the Community Needs Assessment. Despite the lack of clarity in how these strategies were to operate, in rhetoric at least there was still a commitment to include the voices of individuals and communities in population planning and implementation programs.

Another dimension of the Indian population policy of the 1990s was the emphasis on gender. The government's family welfare program aimed to be responsive to the needs of women, emphasizing gender empowerment as part and parcel of the reproductive health approach. Several activities and approaches were identified that would facilitate gender sensitivity in the RCH policy. Early RCH documents explain that the state's policy will take a "life cycle" approach; that is, the state aims to provide health services that address women's health across their life cycle, from childhood to adulthood, encompassing the health of the girl child right through the reproductive years and into menopause and old age. The RCH also talks about the role of men in the reproductive process and bringing male responsibility into the center of family planning policy. Program activities included training for staff on gender sensitivity, and improving health outcomes for girls and women by changing their role in society through education and employment. The state also aimed to improve an understanding of the needs of women through consultation with women's groups and involving them in service delivery and needs assessment.

The language (and to some degree, the practice) of choices is another facet of the paradigm shift in Indian population policy. The programmatic responses of the state sought to bring more choice to users. The family welfare service had always had a "cafeteria" of contraceptive choices but in the 1990s, these choices expanded and so did the providers of various family planning services and products. Contraceptives such as the emergency pill, vaccines, diaphragms, injectables, and sub-dermal implants have all entered or been piloted in the family welfare system at some time or other in the last decade or so. The government is also pursuing private sector and NGO partnerships in the aim to enhance choices for users.[8]

Finally, an emphasis on quality in family welfare services has been noted. Based on the reviews of the family welfare system, there was a concerted effort to improve the quality of services for its users. The government sought to improve quality along three dimensions: *(a)* infrastructural quality, that is, by streamlining the infrastructure and service delivery systems, reducing duplication, and improving efficiency and effectiveness through targeted, well maintained services to clients, *(b)* interpersonal quality, by improving interactions between client and provider, and *(c)* outsourcing and privatization.

THE RCH: A CRITIQUE

The changes in the Family Planning Policy, applauded for substantive improvement, have not escaped criticism. Part of the criticism is aimed at the implementation (or rather non-implementation) of the policy; although the policy exists on paper, on the ground, concomitant changes have not been evident. Field-level studies (see, for example, Health Watch Trust 1999; Santhya 2003) provide evidence that the quality of services for the user of the family welfare program still continues to be poor. Not only are contraceptive supplies irregular but specific practices (such as follow-up by providers, pre-counseling and check-ups) are not undertaken; women clients are still treated with disregard. Similarly, these studies point out the legacy of the system of incentives and targets that still influences program reporting. Despite the overt emphasis on *quality*, success is measured by numerical quantification of goals achieved. In fact, in late 1999, when doctors in the public health sector in Kerala went on strike because (they argued) Kerala was losing ground in the area of implementing national health and family welfare programs, the state's health services responded by assuring the public that the number of sterilizations had actually increased over the previous year (*The Hindu*, December 14, 1999).

Similarly, critical research also notes that the government's policy of choices did not necessarily imply "informed" choice (Santhya 2003; Simon-Kumar 2006). Women were offered narrow opportunities of choice, those that matched the intention of providers wanting to limit births. The volume of unsafe abortions has also been pointed out. Finally, despite the rhetoric of the RCH, critical evaluations point out that training for staff has not focused on gender sensitivity or quality of services (Santhya 2003).

Criticisms have also emerged from concerns that any positive fallouts of reproductive health outcomes for women will be (if not already) negated by the wider context of economic and political change in the 1990s and the new century. The population policies proclaimed by several state governments (namely, Andhra Pradesh, Rajasthan, Madhya Pradesh, and Uttar Pradesh) between 1997 and 2000 are examples of this "wider" context. Contrary to the intent of the ICPD or the RCH/TFA "paradigm shift", these states revived population program strategies based on incentives and disincentives. Their policies recommended strategies such as disbarment from government jobs and political positions for people who either married before the legal age or had more than two children. The two-child

norm contravenes the pro-ICPD commitments of the government, is undemocratic, and exacerbates inequalities between castes, class, and gender. Buch (2005) researched the consequences of these measures on elected representatives in selected districts of these states. In her study, an elected member forced his first wife to be sterilized, and divorced his second wife in order to retain his elected position. Stories of "additional" children being hidden away with relatives and wives being deserted were not uncommon (see also Sama Resource Group for Women and Health 2005). Rao (2006) notes that the population policy restricts candidates from marginal communities in particular, closing up opportunities for their representation in politics.

Equally disquieting are the implications for population policies that have been directly derived from the government's neo-liberal development policies. Following liberalization, the Government of India publicly encourages the corporate/private sector to participate in the implementation of its population policy. The role of private companies, both international and domestic, in producing and marketing contraceptives is increasing. Feminist activists have been concerned about the private sector's role and the creation of a "contraceptive market"— and not without reason. Max Pharma and its Indian company Upjohn in 1994 flouted its conditions of license by allowing sales of the sub-dermal contraceptive "Depo-Provera" over the counter without prescriptions and with little information about its contraindications (Hartmann 1994). The oral contraceptive "Saheli" was marketed as having "no side effects" (Ravindran 1993). Also, with the opening up of the contraceptive market, a wider range of "hi-tech" contraceptives (Depo-Provera implants, NET-EN, vaccines, Cyclofem injections) are being pushed into a health system that cannot assure safe and ethical provision of these "choices". Strategies that are central to neo-liberal reforms, such as introduction of user fees, have also entered the rhetoric of population policy in India.[9] Rao (2004) notes that the population policy of Uttar Pradesh in 2000 made explicit commitments to introduce user fees in order to improve quality of services. Earlier World Bank documents appraising the reproductive health sector in India also made similar recommendations to the Government of India. For instance, the 1997 World Bank's *Project Appraisal Document* (*India: Reproductive and Child Health Project*) makes detailed references to cost-effectiveness and user fees in the reproductive health program:

> . . . the financial implications of . . . charging for a proportion of the costs of medical services, drugs, and vaccines have been calculated as part of project preparation. The opportunity to charge for activities which require universal coverage for effectiveness such as immunisations, and which help implement the right of every woman to have safe deliveries, is limited. However, cost recovery is being piloted . . . . (World Bank 1997: 17)

In sum, the picture that emerges is that the arena of family welfare services in India is markedly turning into a market for reproductive health products and care. The changes in the reproductive health policy landscape mirror policy changes in other societies where policy development is influenced by the discourses of neo-liberalism and post-neo-liberalism. This transition has ramifications for political empowerment as they mold particular state–citizen/woman relationships.

In a recent publication (Simon-Kumar 2006), I deconstruct the characteristics of the "citizen/client" espoused by the Reproductive and Child Health (RCH) policy, to examine the discourses that inform this label. Among the key findings of the analysis was that the "client" in Indian reproductive health policy, despite the policy rhetoric around her/his centrality in population planning, is never intended to have unlimited decision-making abilities like any consumer in the marketplace. The ability of individuals to exercise "rights" over fertility decisions was limited by the contingencies of economic development and the need to make "rational" choices about small families. An example of this idea is summarized in the following comment of a provider in Kerala, who was trying to explain the Reproductive and Child Health policy alongside the fertility limiting goals of the Government of India:[10]

> Two-family norm is a Government of India policy. Limit the family size. So whatever it is, whatever policy we have addressing family identities, *it is always addressing the limitation of the family*. That has not been changed. But we are changing the service-provider point of view and the client service—that is, [providing] quality service. (ibid.: 145)

This comment is a quintessential example of the contradictions that are part of the language of reproductive health policy. The language of client empowerment and control (derived from neo-liberal/market rhetoric) is simultaneously overlaid with the constraining discourses of neo-Malthusianism ("*limitation of family*", "*two-family norm*").

My argument is that the shift toward neo-liberal language of consumerism/management has particular implications for relationships between "citizen/consumer" and the state. By invoking the language of neo-liberalism, the state legitimizes the development of a "marketplace" of population policy. Thereby, the state could justify the emphasis on efficiency, opening up options that were not previously acceptable, such as, encouraging private providers in the production, marketing, and sales of family welfare services and products, and cutting down services and subsidies. In principle, all of this was rationalized as being for the benefit of the "client/consumer".

Similar contradictions emerge in the use and interpretation of the term "gender". The same analysis revealed that despite the exhortations around gender sensitivity and empowerment, when deconstructed, the policy's discourses around "gender" reveal strong neo-Malthusian interpretations. In the excerpt below—part of an interview with a health provider from Kerala—the discourse of motherhood frames the RCH. Inadvertently, the policy practitioner posits women's roles in the "*family, in the society and probably in the nation*" as central to the rationale of the reproductive health policy in India:

> . . . the emphasis is always on the mother and child. There may be some reason for the planners for deciding or taking such a decision considering this mother and child as a unit. *So the role played by the mother in the family, in the society and probably in the nation*. So that is how it goes.

Repeated references both in the policy text and by policymakers/providers locate women in instrumental roles serving the needs of the nation. A Government of India document (1997a: 1) states that the aim of the RCH is "to reduce infant and maternal mortality, eventually contributing to the stabilisation of the population . . .". There is, consequently, little room to interpret terms such as "empowerment" (a term the policy uses liberally) within a framework that reinforces existing political alignments for women. In a wry twist of interpretations, the policy document argues that for Third World women, "gender" interests are framed in their responsibilities to family and community needs. Therefore, to enhance community development (according to the reproductive health policy) is also to enhance gender empowerment. Women's goals and social goals then become aligned as one. The danger here is that once such discourses

become acceptable, it would also be acceptable to subsume women's interests within other social/national/masculine interests.

Similarly, although many of the reproductive problems that women experience are rooted in poverty and unequal gender power, the RCH policy's remedial strategies are directed at public management improvements. The deeper systemic (and political) foundations of reproductive health issues are not identified as problems or addressed in the range of remedies advocated under the reproductive health approach. For example, RCH policy documents use the following public management solutions to address development problems:

> Deficiencies in the arrangements for mother and child health care *lead to* higher incidence of maternal mortality . . .
> An efficient arrangement for implementing RCH programme *is a pre-requisite* for tackling the problem of population growth . . .
> . . . an integrated approach to the programmes *[is] aimed at improving* the health status of young women and children . . . (Government of India 1997b)

In the above, the "problems" identified (such as maternal mortality, population growth, health status) are rooted in complex socio-economic conditions. Yet, these are glossed over by reducing the solutions to better provision of health services. Population issues, therefore, risk moving from a domain of political engagement between citizen and state to that of a contemporary public management discourse around consumer and provider.

In the end, the overlay of neo-liberalism with neo-Malthusianism creates conditions of restriction rather than empowerment, and at best, addresses some health outcomes, not political empowerment. The following excerpt from a senior official in the Ministry of Family Welfare exemplifies the restricted intent and goals that the policy will actually achieve. The goals of the RCH are about "*safe pregnancies, safe deliveries*" rather than changing "*power equations*":

> You have seen the goals that we have defined for ourselves. They *do not—may not tally* with the Cairo declaration. *Our goal is highly restrictive* in terms of trying to ensure safe pregnancies, safe delivery, safe child who passes through the infancy and goes on to childhood . . . most of the goals that we have set for ourselves will be—can be—achieved even independently of trying to work on . . . power equations. (Simon-Kumar 2006: 238)

One can be pragmatic and reconcile these contradictions to the realities of implementing any program within a complex political, bureaucratic, and cultural context. However—and this is the central argument of this chapter—the outcomes of the blend of neo-liberalism and neo-Malthusianism are not innocuous, and stand to jeopardize present and future political empowerment opportunities for women in India.

IDENTITIES AND POLITICIZING THE PERSONAL

Put together, these findings help us draw up a picture of "empowerment" outcomes created by contemporary reproductive health policy in India. Using the concepts that have continued through this chapter—representation, constructions, public space—in this concluding section, the ramifications for relationships between women, reproduction, and the state will be explored.

It is tempting to look at the advances in rhetoric and practice of the Indian state and conclude that despite the implementation "hitches", the government's family planning program is, for once, interested in the welfare of its citizens, especially women. And, as Smyth, whose view set the context for this chapter noted, it is also tempting to conclude that the paradigms of neo-liberalism and/or reproductive health are immaterial if the required health outcomes are achieved.[11] Yet, in tying together the various strands of analyzes covered here, a theme that stands out is that the population policy context in India is not compatible with gender/women's empowerment, especially when empowerment is defined in transformative ways. The relationships between women and the state, manifest in policy and practice, continue to be founded on representations that are inimical to women's political empowerment.

To some extent, this is not surprising. The population policy of the Indian state has, from the beginning in the 1950s, exhorted its subjects to align their reproductive behavior with that of the priorities of the state. Family planning was always projected as a patriotic duty for the nation and as a rational choice for individuals who wanted to lift themselves out of poverty. Thus, in the population and development discourses of India's anti-natalist program, citizens' reproductive activities gave them a place in the productive/political spaces of the state. Women were at

the center-stage of a discourse that positioned them as primary agents of demographic change. As the population policy was embedded within a strong discourse of obligations that women were to discharge, defining women as "responsible mothers and reproducers" in development policy also served to define their political identity. The state, for its part, became the stereotypic authoritarian, relentlessly persuasive, even coercive power, urging its subjects to fall in line with its policy. Through mechanisms of open propaganda, control and limited choices, rewards and punishments, the state assumed patriarchal power, and its people became the object of its command.

The neo-liberal transition of the state is a peculiar, yet important, influence on these erstwhile relationships. On the one hand, the "gender sensitive", participatory state constructs a partnership wherein the state is involved in supporting the "private" activities of individuals. To that extent, the private sphere of reproductive activity is seemingly becoming political as it enters the eye of public debate. However, the simultaneous discourse of the minimalist state reduces the responsibility of the state to address the key issues of equity, justice, and change. Increasingly, because the public space is permeated by other entities such as the market and civil society, the state can rescind its responsibility for being the arbitrator of rights. The commonplace response in government circles is to "pass the buck" onto civil society arguing that it is the role of NGOs to enter the "private" sphere and address issues of power between individuals and communities. It appears that in the view of the state the private sphere is not a political arena wherein it may participate.

Just as the "private" space is rendered politically ambiguous, so also is the public space. If duty and patriotism constituted the subtle rhetoric that persuaded individuals to participate in family welfare programs in the past, now it is the language of consumer empowerment that is being used. Take the case of contemporary contraceptives, most of which are based on sophisticated biotechnology. Rather than feeling "liberated" by these choices, there is unease that women's bodies are becoming more reliant on provider intervention for fertility control, and that the degree of medicalization in reproductive technology is high. At a time in its history when Indian society is increasingly being steeped in consumerism, reproductive health too is becoming one of the products of high capitalism.

Thus, ironically, just as the public space of reproduction is becoming open to "empowerment", it is most at risk of losing its political edge.

While there is considerable evaluation of the reproductive health program's structure and delivery in India, there is less critique of the significance of evolving relationships and discourses between women and the neo-liberal state. The reproductive health issue is currently caught between an ambiguous state, a demanding market, and changing identities for individuals/women. Yet it is through understanding the ideologies embedded in key relationships that the "public" and "personal" can be distinguished. The challenge in determining empowerment outcomes for women in reproductive health is also the dilemma of navigating new territories of "political" in a neo-liberal world.

NOTES

1. Other significant influences on reproductive health policy identified by scholars include neo-Malthusianism (or the philosophy that population control is a necessary condition for the economic productivity of a society) and cultural fundamentalisms (a range of religious and traditional practices and beliefs that specify limiting roles for women).
2. The principles of reproductive health come from two (and merging) traditions, the first, being the international women's health movement, forged during the 1980s/1990s, that focused on the rights of women to make reproductive decisions "regardless of nationality, class, ethnicity, race, age, religion, disability, sexuality or marital status" (WGNRR 1993). The second, and more dominant, source of current understanding of a reproductive health approach comes from the Programme of Action ratified at the ICPD (1994) where concepts such as "quality of care", "bodily integrity", "universal access to services", and "empowerment and rights" that enable women to make sound reproductive decisions (Programme of Action, ICPD 1994) were enunciated.
3. The suggestion that neo-liberal reforms were insensitive to human suffering were recognized as far back as 1988 when Cornia and Jolly published *Adjustment with a Human Face* (see Cornia and Jolly 1988).
4. Western liberal democracies, as I refer to them here, are societies where women's suffrage activities began in force in the 19th and early 20th centuries.
5. There is a subtle difference between equality and equity. While equality aims to have the same entitlements for men and women, equity makes claims for fairness to redress inequality, even if it means positive discrimination in order to achieve equality.
6. The liberal feminists believe in working within the state promoting rights for women through increased opportunities in employment, political participation, education, and so on.

7. http://www.imf.org/external/np/pfp/gambia/gamtabs.htm, accessed April 15, 2006.
8. These "partnerships" are being fiercely rejected by health and women's groups in the country.
9. In general, costs of out-patient and in-patient care have gone up since the 1980s, with increases in the range of 77– 436 percent (see Rao 2006).
10. The excerpts and quotes in this chapter are taken from Simon-Kumar (2006) where details of methodology and analysis are provided.
11. Evidence suggests that health outcomes during this decade have only worsened. Infant and under-5 mortality rates have stagnated through the 1990s, ante-natal care is still accessed by only a fraction of pregnant women, and women are wary of abortion services as they are linked to sterilization (Rao 2006).

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7

A Decade after Cairo in Latin America: An Overview*

Martha Rosenberg

The 1994 International Conference on Population and Development (ICPD) at Cairo is considered a landmark, since it is perceived as having shifted the emphasis in women's health from demographic concerns to women's rights in general, and reproductive health in particular. But to evaluate what has happened to women's health in Latin America over a decade or more since the Cairo conference, one has to analyze happenings in the political sphere during this time; and how Latin America has been affected by "globalization". The use of this term asserts the fact that the effects of the neo-liberal economic system—that now encircles the globe—cannot be isolated from national economies. Exploitation has been globalized with the trans-national circulation of profits; capital can now grow at the expense of the resources and labor of any country in the world. This economic process was, of course, one that began much earlier; indeed, it can be traced back to colonialism. But since the 1980s, the world has entered a second phase of globalization, a phase that became fully functional during the 1990s. Areas of social life that had hitherto not been ruled by the logic of profit were now commercialized. In Latin America, unemployment increased, average salaries decreased, and the precariousness of working conditions grew dramatically. The enormous growth in services linked to the international circulation of financial capital excluded women, rather than bringing them into the high paid sectors.

Public social expenditure was reduced. Services that had been accessible to most people were privatized, thereby increasing inequality between poorer people and the rest of society (Cortés 2003: 67).

These processes of capitalist globalization have increased the pressure on households that are mainly run by women; in Argentina this is nearly one-third of households. Many women have no option but to leave their families and take up insecure jobs in richer countries; others become vulnerable to exploitation in the form of sexual tourism and prostitution (Doménguez et al. 2004). Using examples from Argentina, this chapter describes how the economic changes brought about by the processes of globalization have had an impact on the lives of women in Latin America. These, in turn, are seen in relation to the Cairo commitments. It also traces the reactions of feminist and women's movements to the challenges posed by these changes.

Women's movements in Latin America came of age during the continent's struggles for democracy. This was also a time that demanded the confrontation of deteriorating economic conditions, most of them inherent in the neo-liberal economic regime imposed over the last three decades. Over the 1970s and 1980s, throughout the region, military dictatorships established repressive regimes that set out to undo weak welfare states, and destroy political and trade union movements that had taken anti-imperialist positions. At the same time, many countries also experienced armed revolutionary violence aimed at bringing about a social transformation in favor of the exploited. The feminist movement grew out of these post-dictatorship social movements, albeit in neo-liberal times. It emerged after armed revolutionary struggle was defeated in most Latin American countries. Even movements that emerged from these struggles to hold political power, such as the one in Nicaragua, for instance, could not sustain the ideals they had pursued during the revolutionary struggles once they moved to the phase of government. This historical background is, in a sense, "constitutive" of Latin American feminism; herein lies the connection between the political realm of formal democracy, and the economic sphere of social democracy that the "anti-globalization" or anti-neo-liberal movement regards as central. It is impossible to describe resistance to neo-liberal globalization without taking into account what the women's movement has contributed to this resistance.

THE BACKGROUND TO CAIRO

During the post-Second World War period, social movements generally tended to keep a critical distance from government and inter-governmental structures, both to maintain their autonomy and because of the limits and biases of government promises. But from the outset of preparation for the ICPD, agencies of the United Nations, along with the population control movement and feminist groups from the North, developed a participatory process in which women's groups from around the world took an active part. Latin American feminist groups were no exception. Encouraged by their experience, they began to intervene enthusiastically in the work of UN agencies with the hope of widening their sphere of political activity and influencing the region's moves toward democracy. Thus, the repercussions of the Cairo process on Latin America cannot be underestimated. The trend toward democracy coincided curiously, however, with the expansion of capitalist globalization in Latin America. As a result of the two processes coinciding, people in general, including women, have gained more rights over the past decade since the ICPD, but the conditions in which to exercise them have worsened.

During the 1960s and 1970s, international NGOs and the UN and its agencies formulated various policies in which women from the so-called Third World were the objects of demographic birth control measures. These women usually lacked the power to intervene in the political decisions that affected some of the most important personal decisions of their lives. Women's wombs became the strategic site in which national and multinational power was exercised. In the past decade, however, it has become evident that this is not true of only countries in the South. In the North, too, such control has become a factor, since women are expected to "produce more privileged citizens" in the case of countries that are witnessing a dramatic decline in birth rates. The perception of such a need has to be seen in conjunction with assuaging fears of immigration as well as the means to keep economies going. But although they stem from patriarchal domination, it is evident over the last decade or so that neo-colonial birth control policies are not impervious to processes of political democratization or to the demands from women's movements. When issues of justice, political equality, and economics have to be negotiated, even imposed contraception can be used by women to

"re-appropriate" their bodies, their sexuality, and their reproductive decisions: the technology can be transformed into an instrument of autonomy. In this sense, the policies that came out of the Cairo process signify a hybrid mix of bio-power and rights.

In the 1980s, as democracy took hold in Latin America, many movements—including women's movements—took up the discourse of rights as a cornerstone of their political projects. They made it clear to governments that their cooperation in the social sphere would be ensured if governments were to implement the new "development" agenda of reducing public expenditure and the role of the state.

In the 1990s, when Latin American dictatorships seemed a thing of the past, the inter-governmental nature of the UN seemed to stand in logical opposition to the non-governmental character of those civil associations, primarily NGOs that had participated in the large international UN conferences of the early 1990s. These associations not only emphasized their independence from states, but also lobbied to intervene in government decisions. This is a conflict and tension within every social movement that claims intervention in public policy as its right.

ARGENTINA: THE BACKGROUND

In the 1980s and 1990s, Argentina was an economically dependent country, tied to loans from international financial institutions. Unlike some other Third World countries, Argentina had never tried the path of import-substituting economic growth, relatively distanced from the centers of imperialism. The country was devastated by a bloody military dictatorship that had, with its ally, Catholic conservatism, steadily eliminated a generation of political militants, either through assassination or exile. But the irresponsible 1982 Falklands war, with its huge loss of life, also sounded its death knell. In the new post-Cold War world, military dictatorships were considered passé. Democracy was then ushered into Argentina (as to the countries of the former Soviet Union) along with the neo-liberal policies of stabilization and structural adjustment, under the aegis of the World Bank and the IMF.

Social movements saw rights and democratic norms as a necessary stepping-stone to a change in dictatorial policies. Within this framework,

a section of the feminist movement introduced the concept of reproductive rights. As part of the democratization of society and the right to self-determination, birth control and abortion became basic components of the feminist agenda in a region where both had been proscribed.[1] At the Fifth Meeting of Feminists of Latin America and the Caribbean in Buenos Aires in 1990, participants voted that September 28, should become a day to call for the legalization of abortion in Latin America and the Caribbean. This date was subsequently adopted throughout the region and has since become an important landmark in the building of a regional movement for reproductive rights.[2]

In the early 1990s, laws were passed mandating that a certain quota of elected parliamentary posts in Argentina should be reserved for women. (This has recently been extended to trade unions.) But the existence of legislation does not necessarily mean that cultural barriers to the entry of women into the circles of power have been dismantled. A woman can easily become a parliamentary candidate by being nominated by some political party; often these women come to power through their links with a powerful man (who is not necessarily a candidate from a conservative party). Many women who have no ideological commitment to feminism have won parliamentary seats thanks to feminist lobbying for the women's quota. As a result, Parliament has had a history of rejecting many proposed measures related to reproductive rights. It took 13 years, for instance, before a law setting out a National Program of Sexual Health and Responsible Procreation was passed in 2003, and the law still does not include the right to abortion or surgical contraception.

The presence of women in Parliament may have helped to pass some laws that address the predicaments many women often find themselves in. The Law of Protection Against Family Violence (1995) and the Law of Sexual Freedom and Responsible Procreation (2002) are examples of these. But it is obvious that the existence of women legislators is no automatic guarantee that women's reproductive and sexual rights will be defended.

The National Program of Sexual Health and Responsible Procreation emerged, then, as the delayed outcome of the Cairo Programme of Action. This had long been the demand of working class women, who had mobilized to fight for both economic and political rights as well as sexual autonomy. The program met with resistance from large sections of

the Catholic Church and from conservative sections of the medical establishment who lobbied extensively against it despite their ostensible support for the struggle against poverty.

REPRODUCTIVE RIGHTS: WESTERN FEMINIST AGENDA?

Are reproductive rights simply a cultural import or an imposition by Western countries and the population control lobby? The Catholic Church in Argentina often puts forward this argument to stop women from defying the Church's position on sexuality and procreation—rules that keep women confined within notions of "natural" maternity, supposedly ordained by divine laws.

This argument about authenticity does have resonance in many Third World countries. In Latin America, for instance, there has been hegemonic agreement on the "culture" our countries belong to and on the values that govern social life. In Latin American countries, especially those of the Southern Cone, that went through a continuous process of inter-mingling of European conquerors and immigrants with indigenous peoples or *mestizaje*, no alternative culture is now available to dispute this hegemony. Only with the emergence of movements—the Zapatista movement in Mexico and other movements that claim their descent from native cultures—have the decreasing numbers of indigenous peoples acquired a specific political identity. These are people who have been dominated first through colonialism and then by its native inheritors. The region is not homogenous, however; other countries, particularly in the Andean basin, have mainly indigenous populations. In Argentina, colonial plunder and the genocide of native peoples and people of African descent enslaved during colonial times have largely been ignored. Only recently have such subjects become part of the political agenda of the Left. Indeed, there is still a reluctance to publicly highlight the racism present in Argentine society.

In this context, a huge impoverished middle class, which had survived the economic adjustments imposed by dictatorial regimes since the 1970s, breathed a sigh of "democratic relief" when the last military dictatorship fell in 1983. At this time, many social movements victimized by political and military repression re-emerged. One such was the feminist movement.

Many women who had been in exile in Europe or other Latin American countries returned. When preparations began for the 1994 ICPD, a second wave of feminism was already resurgent in Argentina. Middle-class women, political militants or ex-militants, academics, or intellectuals were predominant in this movement, which once again forged their traditional ideological reference points with emancipatory policies of European origin. In Latin America, especially in the countries of the Southern Cone, feminism is clearly of European and North American origin; not least because all our political culture, including that of the traditional Left, has been constituted through the assimilation of the best and the worst of Western culture. The political culture of the masses, represented by *Peronism*, is a synthesis of popular representations of stereotypes and gender relations and it remains steadfast to traditional values of Western and Christian culture, forming part of what is called "the national self".

Participating in the ICPD consolidated the integration of Latin American and Caribbean feminist movements into the structures of multinational negotiations, revealing their multi-lateralism and internationalism. This was a characteristic of the 1990s, when several large international conferences on women's rights were held. The advances in national legislation on the rights and the status of women are directly related to the international commitments made by the Argentine government in these conferences and conventions, commitments that began to form part of our National Constitution after 1994.

CONFLICTS IN THE MOVEMENT

In any movement that emphasizes legal reforms, there is constant debate about the distance the movement should maintain from government institutions and economic power. The relationship between feminists of the "North" and the "South" (a distinction that does not express the internal heterogeneity of the two but the cultural traits of the class and ethnic differences between women) is another important topic of debate. South and North symbolize the unequal distribution of the world's economic power, but also hide the complexity of myriad political postures within the two geographical areas. Unfortunately, emancipatory ideas do not

emerge automatically as the birthright of oppressed women and men. As feminists, we know that many of our rights are compatible with the existence of capitalism. Nonetheless, we still want and defend these rights; indeed, we are obliged to struggle for them. They are ours; they belong to the horizon of freedom without which no revolution is possible.

Participation in ICPD strengthened a large group of veteran Latin American feminists and international feminists. They transformed this experience of activism, debate, and negotiation at the highest levels into political and organizational relevance for women's movements, as well as the general struggle for access to resources. Many women with roots in feminist militancy and other political affiliations affirmed their feminist socialization during their preparation for, and participation in, these international conferences. The entry of the movement into a domain of global power gave it a logic and momentum; it was able to engage in both dialog and conflicts at international levels, a strategy that emerged as a new one for the feminist movement. The debate on the possibilities for feminist autonomy within the bureaucratic structures constructed by states to sustain patriarchal domination still continues. The consequences and risks of co-option by these kinds of structures are constantly evaluated and experienced—the co-option of people, discourses, objectives, and styles of relationship. This debate has been carried on in the feminist meetings of Latin America and the Caribbean (Álvarez 1998), and it is relevant because Latin American women, especially feminists, have made significant advances in recent years in getting women's quotas in political representation and in government posts. There is a permanent tension between the logic of the political party—which tends to be male-centered and traditionally authoritarian—and that of the feminist movement, or personal critical consciousness raised to a political level. There are frictions and divisions within feminist groups and ideological leadership has been eroded. There is also strong political skepticism as to whether feminism can be integrated into other organizations and whether such organizations have the capacity to modify their patriarchal premises. This process has continued with the participation of the feminist movement in the World Social Forums (Álvarez 2003), reflecting a struggle among political positions; a struggle that embodies a conscious pluralism and diversity but cannot be resolved easily.

FEMINISM OR FEMINISMS?

What does it mean to be a feminist? The US historian Joan Wallach Scott has said that the term "feminism" refers to several movements with, possibly, vast differences among them (Scott 2004). Such differences can be understood in the present historical circumstances as "translations" that create a space between the global and the local. In many cases, however, the translation is not faithful to the supposedly central doctrine. One of the functions of language is enabling the speaker to diverge creatively from an imposed meaning. In the process, even the concept of universality with its implicit emphasis on homogeneity is called into question. Indeed, its very impossibility is made manifest by the "infidelity" of translations. Thus between the global (singular) and the local (singular), the plural of different versions is introduced. We can only in fact speak of "feminisms" in the plural. Supposedly unfaithful translations indicate the shifting positions that different subjects articulate. What we share as women, as feminists, as a movement (singular), however, is the entitlement to speak, even if we do not share *what* we speak about. We are different and get strength from our differences.

Feminism and gender do not emanate from an original point in a uniform centrifugal manner. They acquire meaning according to local contexts, meanings that move toward the periphery and return to their origins. To describe this movement, Scott uses the metaphor of an echo and its reverberations, signifying shifts in time and space, and, in the process, creating a history. As signs and what is signified are transmitted, they create a cataclysm in their wake: successive echoes from seismic waves in far-flung centers leave behind changed geological formations. The reverberations of feminism, argues Scott, "have not had the force of an earthquake but have made all kinds of alterations, laterally and longitudinally" (ibid.: 14). These alterations constitute the memory of the effects of its movement. These metaphors represent the construction of a world—the world of feminism—a world in which power, as it circulates, changes the ground that sustains us, the land we inhabit, and the language we use.

Since the attack on the World Trade Center on September 11, 2001, the world seems to have slipped into a simple binary mode, even as it has entered a state of permanent war. Thus "the axis of good" versus "the axis

of evil", secular Western rationalism versus Islamic fundamentalism, modernity versus primitive tribalism, and so on. But these dichotomies do not explain the real differences between the feminisms historically constructed in the North and in the South. Emphasizing the differences, however, allows us to see what we share: the idea that women are subjects in their particular contexts and that women are agents of their own history. No feminism, however enlightened, Western, and hegemonic, can prevent "Others" from taking their destiny into their own hands and making their voices heard.

HEALTH POLICIES

Neo-liberalism has been the guiding principle of public policies, including health policies, across the globe. Yet these policies have never had the results predicted by those implementing them because the policies have invariably been altered by their encounter with resistance or support, depending on the strength and orientation of women's movements and their connections with other social movements. On the other hand, they have also had results that have been predicted, such as creating markets in health care even as they have reduced health care access to the poor and even to the middle classes. Latin America has been affected in many ways by the macroeconomic policies of neo-liberalism, introduced at the behest of the World Bank and the IMF, that have increased social inequalities. These policies have increased women's absolute and relative poverty because they have increased women's workload even as public expenditure on health was reduced and unemployment increased (Dirección Nacional de Estadísticas y Censos 2003a: 11).

The economic logic of neo-liberalism creates poverty and non-economic forms of domination: women's time and energy get increasingly used up in maintaining social and family order. Public health policies have been an important part of the neo-liberal globalization processes that have reduced public services and the role of the state to the bare minimum. In Argentina, plans to reform the health sector and decentralize the health system have, in practice, been plans to privatize medical care—privatize in the dual sense of handing over to for-profit interests and to the domestic, possibly hidden, realm. Public health care resources, for instance, are

reduced to a commodity access to which depends on a person's position in the market, not on human or citizen's rights. Women, meanwhile, have to care for the sick in the private domestic sphere as public services are replaced by women's voluntary and unpaid labor (and by NGOs that substitute for the role of the state). This logic of privatization creates deep gender inequalities in women's access to quality health care, depending on their location in the social ladder. Moreover, women suffer from globalization in specific ways because they tend to be more dependent on social expenditure than men.

For its part, civil society has demanded that governments guarantee the right of women to health services, and to legal, educational, and medical resources. These objectives are in keeping with the declared principles of the ICPD's Programme of Action, which does not confront the inconsistencies between a discourse on rights and the actual effects of neo-liberal capitalist globalization. Take, for example, abortion, which was addressed by the Argentinian Ministry of Health as a major public health problem whose legalization would solve the serious problems of morbidity and mortality caused by illegal abortions. The complications caused by illegal abortions often ended up as a burden on the public hospital system while ruining women's health and affecting the country's indices of national human development. This political initiative and its accompanying declarations from the Minister of Health would not have been possible without the feminist movement using the Cairo discourse and government commitments to give credibility to our historic demands.

In Argentina, 16 percent of the economically active population is unemployed, while informal and precarious employment has become the norm for the majority, especially for less qualified or skilled women. (Dirección Nacional de Estadísticas y Censos 2003b). Between 1991–99, two million people who used social welfare benefits lost them (CEDES 2003). Between 1999–2000, sudden unemployment expelled another 1.85 million people from other social welfare schemes. One result has been huge and growing social differences in access to resources and services. In the past 10 years, the gap in the per capita income between the richest 10 percent of the population and the poorest 10 percent has grown by an astonishing 70 percent.

Even in 2005, when the economy had begun to recover and show higher growth rates after years of stagnation caused by the country's foreign debt,

income gaps have increased. Wealth is increasingly concentrated; hence poverty is increasing. Neither neo-liberalism nor the World Bank and IMF prescriptions have guaranteed better living conditions for those sectors of society stuck in deep misery. More than 42 percent of households and 54.7 percent of the urban population live below the poverty line, and 18 percent of households and 26 percent of people below the indigent line (Dirección Nacional de Estadísticas y Censos 2003b: 17). Women head 30 percent of households while 60 percent of children live in poor households (ibid.). Till May 2004, the indices for poverty and destitution were not only on the rise, but also spreading to other social groups. The minimum wage, despite being increased by the government of President Kirchner, still did not cover basic needs in May 2005.

Uncontrolled commercialization of all fields of activity has eroded much of the Argentina's social fabric. Its correlation with competition and individualism has gone hand-in-hand with the overall attitudes of resignation, desperation, and failure. An increase in sexual violence against women, violence in schools and public places, sexual assaults in the workplace, the marked inequality in wages and salaries, the unstable nature of work, the sexual abuse of girls and boys, and the rapid break-down in people's planning for the future because of the lack of social development—all these are indicators of the social fragmentation caused by trans-national finance capital destroying the production system and the accompanying social support system.

Such a desperate situation has spurred large sections of society to mobilize in resistance. These sectors include the middle class, which lost its savings when the economy was delinked from the dollar; the movement of the unemployed who, with varying degrees of autonomy from the state, cooperatively manage to survive; some businesses and factories that have gone bankrupt because of fraud and others now managed by the workers themselves; rural movements reclaiming possession of their land; and many others that are coming together with various social, cultural, and political identities. Women have had an important role to play in building the very foundations of such movements. The women's movement itself has generated many projects and initiatives and developed many strategies of resistance. One specific area of focus is sexual, domestic, and work related violence and any kind of sex-based discrimination.

Some of this resistance is not the result of carefully thought out strategies or conscious projects. Instead, they comprise spontaneous actions in which the subjectivity of those fighting to overcome unfavorable conditions of survival is affirmed. Such actions can be considered an exercise of the "power of the weak" because they are applied to "programed customs of disbelieving"—rejecting the ways in which the stronger actors in society define the weaker as responsible for the aggression they have suffered (Janeway 1981).

The practice of abortion[3] could be seen in this light as a woman's refusal to accept maternity as obligatory (an obligation to fulfill the equation of woman = mother). This is particularly true for a situation in which a woman faces an unwanted pregnancy that could not be avoided for several reasons, including the lack of sexual education, the lack of access to contraceptives, and also because of the asymmetrical power relations between the sexes. But can some kinds of resistance to hegemonic domination be read as reactive forms of self-destruction? Suppose we consider certain types of behavior that seem self-destructive. Can this be the way to view the fact that only a small proportion of adolescents make regular and correct use of contraception (Iglesias 2005)? Even when they have the information on how to prevent transmission, they expose themselves to sexually transmitted diseases, or become young mothers and fathers, or have abortions, or consume toxic substances from an early age (Checa 2003). All such behavior is evidence of the failure of social networks in reaching, protecting, or covering those they are intended to shelter. The social damage of such failure has been extensive. It seems impossible to have a productive life, particularly with the mass media's powerful, inescapable perpetration of sexuality both within traditional gender stereotypes and commodification. The fatalism of a social class, many of whom have experienced three generations of unemployment, cannot easily be converted into an interest in finding out how to take care of one's health or the self-esteem required to do so.

In the field of women's health, two areas need particular attention: the frequency of repeated unwanted pregnancies that lead to abortion; and women's exposure to HIV even when they have appropriate preventive information. Among those who have HIV/AIDS, the proportion of those who are homeless or marginally housed (H/M) has risen from 3.2 percent in 1988 to 20.4 percent in 2001 (MOHE 2001). The mode of transmission for men is largely through intravenous drug use; for women, it is through

heterosexual intercourse. The 19,193 cases of AIDS registered in 2001 in Argentina suggest an accumulated rate of occurrence of 50.6 per 100,000 persons. Of these, 6.9 percent are children less than 13 years of age.

There is a host of evidence to indicate how deeply women are devalued in Argentinian society: an increase in prostitution and commercial sexual relationships; the tolerance of sexual violence, including criminal violence against those who remain in violent relationships; the acceptance of the uncontrolled exploitation of women's labor in sweat shops; and the wide income disparities between men and women, ranging from 35 percent in salaries at the lower end of the scale to 48 percent in professional posts requiring high qualifications. Women internalize these degraded gender images as inherent to their sex, an internalization that is an obstacle to their defense of reproductive and sexual rights as well as their adoption of preventive behavior.

The politics of establishing, defending, and widening reproductive rights has always been part of the feminist movement's attempts to confront differences based on sex and gender, class, access to resources, ethnicity and culture, age, or erotic-sexual orientation. All these differences have meant that women, and others who do not follow gender norms, experience inequality, injustice, and discrimination.

From the outset, the Latin American feminist movement identified the 1994 ICPD process as an arena of necessary political intervention. It recognized the need to make an impact in the text of the Platform and then to use this in the defense of reproductive rights as human rights in national contexts.

But the ICPD took place as capitalism was expanding throughout the world and was being portrayed as the only possible economic system. And the women's movement did not make a similar commitment to challenge the development criteria being taken for granted in Cairo. As Chusa Lamarca Lapuente has pointed out:

> We have begun to believe that this is the only world possible, that globalisation is an unstoppable and irreversible process. All its myths, disguised as the objective and rational truths, prevent us from acting, and lead us to believe that the only response possible is one of pragmatism, acceptance and adapting. (Lapuente 2004)

The structure of the global power that determines women's exclusion, as well the distribution of wealth and power, is never questioned. This is

the paradox for those struggling only for sexual and reproductive rights: what is the real scope for these struggles to transform the fundamental and real conditions of women's lives? For many women in the North, addressing these structures of power should be an ethical priority because their well-being is increasingly dependent on the labor of women in the poorest countries, on the general degradation of work, and the environment of the whole planet. But many women's organizations (and others in the First World) are not conscious of this link. For Latin American women, who form a major part of those excluded by globalization and ravaged by poverty, the main focus of their participation in the anti-globalization movement is their struggle against neo-liberal capitalist monopolies.

The participation of the Latin American bloc in the World Social Forums gave the women's movement the experience to reject—indeed defeat—the gender fundamentalisms of the US under Bush, the Vatican, and some Islamic countries in all Cairo Plus Ten fora. These conservative forces could not push back the Cairo and Beijing platforms in any of them. Nonetheless, the USA continues to exert pressures in other bilateral scenarios. There is a contradiction between the expansion of rights and capitalist globalization. At the moment it does not appear as if the new Latin American governments can move toward a just and sustainable alternative model of development in the region. Feminists in Latin America have realized that sexual and reproductive rights cannot be reached without enabling social and economic conditions. Only in the context of just redistribution of the wealth produced by all our efforts is it possible to resolve—with justice—gender oppression.

ACKNOWLEDGMENTS

NOTES

1. "Democracy in the country and at home" was a Chilean slogan later adopted in Argentina.
2. In Latin America, it is estimated that more than 4 million abortions take place each year in unsafe and illegal conditions. The region has the second highest abortion rate in the

world after Eastern Europe. The percentage of all maternal deaths caused by unsafe abortions is extremely high at 24 percent; this is double the rate in Africa and similar to that in Eastern Europe (WHO 1998). In Argentina, clandestine abortions have accounted for the highest cause for maternal deaths for many decades now, an estimated 31 percent of all maternal deaths (*Estadísticas Vitales* 2003).

3. There are more than 500,000 abortions each year in Argentina but less than 700,000 births (Checa and Rosenberg 1996: 29).

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8

Redefining and Medicalizing Population Policies: NGOs and Their Innovative Contributions to the Post-Cairo Agenda

SUSANNE SCHULTZ

> *Whereas the white "female body" might undergo surveillance by the reproductive machine, the dark "female body" is subjected to a dis-reproductive apparatus within a hidden, racially coded demographic agenda. (Shohat 1997: 185)*

"QUIET DIPLOMACY" IN PERU

During a visit to rural communities in Peru in 1998, I learnt about a national sterilization campaign carried out under President Alberto Fujimori (who was widely criticized for his authoritarian leadership style and human rights abuses).[1] The "National Programme for Reproductive Health and Family Planning", which started in 1996 as one of Fujimori's political priorities, imposed a wide range of "incentives" and "disincentives" on Peruvian women and men. "Sterilization festivals" were held at which bands played free music, hairdressers provided free haircuts, and dentists offered free treatment. But these enticements were not always sufficient. Public health care civil servants had to keep with their allotted "quotas" of a certain number of sterilizations each month because of other incentives and disincentives imposed upon them: a bonus at the beginning of the campaign or just keeping their jobs as the campaign

progressed. They visited poorer families in their houses and threatened to denounce them as subversive if the women would not consent to being sterilized, or tempted them by promising to waive the fees for an assisted hospital delivery if a pregnant woman would agree to be sterilized after giving birth. Food aid became conditional upon sterilization. There were also cases where neither an incentive nor a disincentive was employed but simply direct coercion. Some women, for instance, were detained in a health station and forcibly sterilized. In total, an estimated 300,000 persons (mainly women, but at least 10 percent men) were sterilized in Peru between 1996 and 1998 (Barthélémy 2004; Tamayo 1998, 1999). The target groups were indigenous women and men, urban poor, and rural non-indigenous people. At least 20 women died as complications were not addressed.

Yet when adverse publicity about the sterilization campaign emerged in 1998, large national and international women's health NGOs exhibited a very restrained reaction. The Peruvian feminist NGO, Movimiento Manuela Ramos (Manuela Ramos Movement), later explained this reluctance to speak out by referring to its intention to pursue "quiet diplomacy" instead (Galdos and Feringa 1998: 29). At the time, this NGO, together with the other influential Peruvian feminist NGO, Flora Tristan, was participating in the Tripartite Commission, which comprised Peruvian government representatives, the international donor community, and NGOs and other representatives of civil society working together to coordinate the country's population programs. Generally speaking, the women's NGOs regarded this "reproductive health program" as a positive opportunity to enhance women's health policies in Peru. Arguing that criticizing the program would play into the hands of the Catholic Church in the country, which was opposed to women's access to contraception and abortion, they opted to continue their dialog within the Tripartite Commission when these violations of human rights became publicly known. In 1998, they did participate in some public protests at the sterilizations, but in 1999 signed a declaration of the Tripartite Commission, aimed at the United Nations' "Cairo Plus Five" fora.[2] This declaration denied that there had been a coercive sterilization program and played down these sterilizations as sporadic abuses (Barrig 1999; Schultz 2000; Tripartite Commission 1999).

This version of events was also adopted by international women's health networks. Development Alternatives with Women for a New Era (DAWN), an international feminist network of Southern activists, portrayed the Peruvian reproductive health program as a success in its monitoring study of the implementation of Cairo's Programme of Action, mentioning an "episode of sterilization abuse" only as an aside (DAWN 1999: 27). Another similar study by the Latin American and Caribbean Women's Health Network (LACWHN) did not mention the massive sterilization program at all (LACWHN 1998).[3]

Over a decade later, smaller, locally-rooted Peruvian NGOs (and some women's human rights organizations[4]) are still struggling for these human rights violations to be recognized and addressed; and for compensation to be paid to the women or their family members. And still today, the participation in the sterilization program of international population agencies, which readily provided more population funding to Peru in the later half of the 1990s than to any other Latin American country (UNFPA 2001), remains obscure because there has been no serious monitoring or investigation into these international influences (Liagin/Information Project for Africa 1998; Schultz 2005).

SPEECHLESSNESS IN A NEW HEGEMONIC PROJECT

What could account for or explain the immense silence maintained by large women's health NGOs about these Peruvian events, given that they took place so soon after the celebrated 1994 United Nations' International Conference on Population and Development (ICPD) held in Cairo? After all, the ICPD's main outcome, its Programme of Action, clearly acknowledged that a woman's freedom of decision-making concerning procreation was paramount, as was respect for reproductive health. Why did feminist NGOs not make use of political instruments such as the Programme of Action and its language, using all their expertise and professional skills acquired in the run up to the ICPD, to react adequately and swiftly to denounce these Peruvian policies?

That they did not want to give any support to bolstering the influence of the Catholic Church was confirmed to a certain extent when a subsequent Peruvian government under Alejandro Toledo, who had led

the opposition against Fujimori and was then elected president during 2001–2006, appointed as health minister—a person connected to Opus Dei (the Catholic Church's international organization that works to spread Catholic teaching), who promptly described all the sterilizations carried out during the Fujimori campaign as coercive and voted to cutback the family planning program. But a less favorable explanation of the women's NGOs' reluctance to speak out could be because of their relationships with international donors at that time. Shortly before the sterilization campaign was launched, the two major Peruvian feminist NGOs had both applied for funding via a huge USAID-instigated project. Manuela Ramos won the tender and began to implement ReproSalud, one of the most extended feminist NGO health projects worldwide (USAID 1995).

It is not enough, however, either to legitimize the involvement of feminist NGOs in these policies as bitter pragmatic necessity nor to denounce them as the effects of co-optation. Instead, they have to be analyzed as an expression or an example of the transformation of the hegemonic project of international population policies.[5] This project had, on the one hand, been influenced by the international women's health movement, particularly through their involvement in the ICPD process, but on the other hand, the mainstream of internationally-active women's health networks had themselves been integrated into the project in the context of their NGOization.[6] This hegemonic project is characterized by specific frames of analysis and by specific speaking positions within which certain political questions can be asked while others cannot; and certain problems can be addressed and politicized but others can neither be addressed nor politicized. The events in Peru provide the opportunity or stimulus to ask questions about this general speechlessness, to address the unease that is behind it, and to explore the sense that perhaps there is a "hidden agenda" at work.

The so-called consensus of Cairo—the historical alliance between a section of the international women's health movement and the "population establishment" as the network of multilateral, national, and private agencies dedicated to reduce world population growth (Higer 1999; Hodgson and Watkins 1997)[7]—provides the essential background to understand this speechlessness. This consensus led to an "ideological schizophrenia"[8] in

population policies between the micro level of individual body politics and the macro level of strategies aimed at managing populations. At the micro level, the Cairo Programme of Action (UN 1994) refers to the principles of individual freedom of decision-making, reproductive rights, and empowerment, and rejects the direct implementation of demographic goals in the form of targets, quotas, or incentives. Yet it continues to legitimize demographic goals at the macro level such as goals involving reduction of population because reducing population growth is one of the core aims of the Programme of Action and international population programs.[9]

My central argument is this: efforts to silence or ignore this "ideological schizophrenia", or to interpret it as harmonic constellation, represent a crucial moment in hegemonic post-Cairo policies; women's health NGOs were successful in their use of concepts, such as reproductive rights, reproductive health, and empowerment, in the Cairo conference and afterwards only because they contributed productively to this constellation—at the expense of ignoring and depoliticizing certain problems and questions, or even effectively striking them of the agenda altogether. This argument provides the background for this chapter, which explores the NGOization of women's health movements and their productive contribution to the hegemonic project post-Cairo. First, I outline my approach toward the concepts of hegemony and NGOization. Second, I provide analysis of the restructuring of international women's health networks during the Cairo process, their history of NGOization, and some of the internal conflicts involved in this hegemony building. Third, I depart from this actor-oriented perspective and employ discourse analysis to show why certain concepts of gender policies gained in ascendancy during the process of constituting a new hegemonic project of post-Cairo population policies. I do this by analyzing feminist contributions toward redefining the term "population policies" and their "post-catastrophic" neo-liberal turn since Cairo. I also argue that the very focus on reproductive health (rather than explicitly on demographic goals) made it possible to reformulate anti-natalist objectives (albeit indirectly) as the management of reproductive risks at the micro level of individual behavior and responsibility for one's self. This approach adapted to and accommodated the neo-liberal restructuring of the relationship between the state and the individual.

NGOIZATION, HEGEMONY, AND STRATEGIC SELECTIVITIES: SOME THEORETICAL KEYNOTES

> Women's NGOs in Peru have to balance many competing interests, being both insiders and outsiders within the political process. [. . .] NGOs and women's groups are often called upon to play a new role and postpone denouncing government actions in order to retain the possibility of having an impact.

> Mabel Bianco, member of HERA, speech at a Women's Alliance preparatory meeting for Cairo Plus Five in 1998.

As a first step in understanding the role of women's health NGOs in population policies since the 1994 ICPD gathering at Cairo, it is helpful to consider more generally the processes by which some social movements have become institutionalized as NGOs in order to understand their new role within the state or within "internationalized statehood".[10] I refer to neo-Gramscian approaches[11] that do not regard NGOs as a sphere of civil society separate from the (internationalized) state, but as part of the "integral state" insofar as they contribute to the development of hegemonic forms of problematizing certain issues and thus the solutions proposed to them (Brand 2000; Brand et al. 2001). When knowledge networks and public spheres emerge at the international level and participate in negotiating international policies, Gramscian concepts developed in the context of the nation-state can be applied and adapted to international policies to emphasize that political power at the international level, as at the national level, is not simply the result of economic and military dominance but also of processes of construction of hegemony (Demirovic 2001).

Neo-Gramscian analyzes do not understand or explain NGOs in isolation, but situate them in the context of the current transformation of statehood. They show that the rise of NGO policies and actors at the international level stems from a crisis within older corporatist models of representation and political negotiation.[12] In the course of neo-liberal restructuring of nation-states over the past two decades, however, and the internationalization of politics,[13] these models have been replaced by multiple, fragmented organizations that are neither democratically controlled nor accountable to the general public. They have tended to react to this crisis but they have not solved it by establishing what seems to be representative politics, albeit without representation. These developments

are illustrated by the dominant political style of many NGOs, which tend to orient themselves toward a pragmatic shaping of state-oriented politics (to the neglect of protest or social movement politics). They tend to favor "lobby" and "dialogue politics" in so-called governance networks—integrating themselves or being integrated into the "integral state" as experts, political consultants, or service providers. Within NGOs themselves, such pragmatization of politics is often justified by various logics of institutional preservation that aim simply at keeping an NGO going and is supported by NGOs adopting entrepreneurial management strategies, increasing internal bureaucracy, and by their becoming more "professional" and formal.

This understanding or perspective on the processes of NGOization can help in analyzing more generally the integration of feminist NGO politics, their political practices, and their styles of policy-making into the framework of international population policies.[14] Nevertheless, merely detailing the specific success stories and adoption of feminist and gender political concepts in post-Cairo population policies would not be sufficient.

This is because, in population policies, neither integration of private organizations into government strategies nor internationalization of politics are new phenomena; both have long shaped the very constitution of the population establishment. Initially, the regime of international population policies emanated after the Second World War from a network of private foundations set up by wealthy US industrialists and private family planning organizations. In the mid-1960s, the US government itself began to champion the goal of reducing world population growth. It channeled its efforts, however, through these private organizations, including think-tanks such as the Population Council, foundations like the Ford Foundation, and family planning organizations coordinated by the International Planned Parenthood Federation. The government's ultimate aim in doing so was to establish anti-natalist population programs in subaltern countries.[15] A crucial factor in this initial "NGOization" of population policies was that the US government was very keen to play down its role in this politically sensitive issue and the amount of financial resources it was directing toward it (Donaldson 1990: 70). Thus, although it is true that the percentage of international financial resources for population programs channeled through NGOs increased over the last

decade from 41 percent in 1992 to 57 percent in 2002 (UNFPA 2004a: 24), this is not, in fact, a qualitatively new trend in the field of population policies.

Toward the end of the 1960s and beginning of the 1970s, country after country instituted a population program. Such rapid internationaliza-tion of anti-natalist population programs was facilitated by their integration into UN policies through the establishment of the UNFPA, into World Bank policies through its population offices, and into the World Health Organization through its Human Reproduction Programme. This policy integration in institutions with a global reach and remit was necessary because of the policy's political sensitivity at the time.[16]

Therefore, the internationalization of politics is not a new context or phenomenon for the NGOization of social movements as far as population policies are concerned. Instead, its institutional build-up results from simultaneous processes of both internationalization and nationalization, as population programs, offices, and institutions were established in countries of the South as processes of *national* institution building. A 1998 UN report indicated that the number of national governments implementing anti-natalist population programs increased from 49 in 1976 to 76 in 1996 (UN 1998).

But if international NGOization in the field of population policies is not new, what is different is the type of NGOs that have been integrated into the population regime, and the type of "speaking positions" that have been allowed—and silenced—in this regime. When women's health experts with a background in social movements speak about gender and health on the internationally-established population scene, their presence signifies a dramatic departure from the previous "speaking positions" of conservative Northern philanthropic and elite industrialists, particularly when they claim to represent women in Southern countries as the main "target group" of population programs. It is certainly because of feminist movements' struggles that this new speaking position could be anchored so successfully in the hegemonic project of post-Cairo population policies. Since the 1980s, such movements have made enormous efforts in a coordinated manner for human rights in the spheres of procreation and sexuality to be recognized and realized. They have strived for women to be recognized as autonomous individuals, not just as part of a couple or a family, and to be acknowledged as active decision-makers, not simply

passive acceptors of contraceptives whose reproduction can be easily instrumentalized for (bio)political purposes. Nevertheless, analysis of the successful incorporation of gender and health concepts within the regime of international population policies in the Cairo Programme of Action and in population policies since 1994 has to go beyond this consideration of the relationships between social forces. After all, it needs to be explained how and why it was precisely on this conservative terrain of population policies, with all its neo-Malthusian and eugenic traditions aimed at protecting the dominant status quo,[17] that gender politics have been evaluated as the most successful of the 1990s and from which "possibly the most feminist document" of the decade emerged, the Programme of Action (Tinker 1999: 100).

Any explanation of this success has to pay attention not only to relationships of power, but also to the strategic selectivity[18] of the terrain of population policies itself. The concept of strategic selectivity highlights that struggles involving population policies are not taking place on a neutral terrain; instead this terrain has already been structured by certain forms, functions, and rationalities. It is the very permeability of the terrain of population policies, their ability to adapt to new constituencies, that allowed gender and health concepts to "pass through"[19] in the process of transforming the new hegemonic project.[20] These concepts were allowed to pass through and be taken up because they were useful and productive for the Cairo consensus and the post-Cairo constellations.

The precondition for this productiveness of gender political concepts (as well as their effects) was a change of hegemony within women's health networks themselves. This change took place before and during the UN ICPD Conference in Cairo and helped various positions within the international women's health movement to gain power as they could make this offer to the international population establishment.

CONSTRUCTION OF HEGEMONY INSIDE THE INTERNATIONAL WOMEN'S HEALTH MOVEMENT

Various research projects and publications have analyzed the transformation of the international women's health movement since its international articulation in the 1980s, and have outlined conflicts within it and

its restructuring both before and during the ICPD (Higer 1999; Hodgson and Watkins 1997; Nair et al. 2004; Schultz 2005). I summarize this heterogeneous and conflict-ridden history so as to hint at some important aspects in understanding post-Cairo constellations.

A milestone in the international women's health movement's history was attained in 1984 in Amsterdam, The Netherlands, at a meeting hosted by the ICASC (International Contraception Abortion and Sterilization Campaign) and Platform Population Politics. This was the first time that different groups across the world—some 400 women from 65 countries attended—began to feel that together they constituted what could be termed an internationally-linked women's health movement, united under the meeting's theme, "No to population control, women decide".[21]

As a result of this meeting, several women and groups decided to form the Women's Global Network for Reproductive Rights (WGNRR) as a coordination network. Another important event in the history of the movement took place eight years later when a group of gender experts came together in 1992, a group that I will call the "women's voices" group after a statement they issued in 1992 (see the discussion in the subsequent paragraph). This group proposed that feminist groups should revise their overall rejection of population policies instituted by the state and opt instead for dialog and negotiation with the population establishment that was preparing for the ICPD. This "women's voices" group was initiated by the International Women's Health Coalition (IWHC), a group of "population femocrats" in New York, some of whose directors used to work within population institutions such as the Rockefeller and Ford foundations. They brought together a group of feminist gender and health experts who subsequently became some of the most important lobbyists during the ICPD, the architects of the Cairo consensus. This group of NGO experts maintained a constant dialog with the population establishment after the ICPD and could be said to have become a trusted partner. Population agencies treated this group and their concepts and ideas as *the* representatives of women's health issues. By the time of the Cairo Plus Five process in 1999, the same group of women's voices coordinated the activities of a "Women's Alliance" under the label of HERA (Health, Empowerment, Rights, and Accountability).[22]

Between these two milestones of 1984 and 1992, political practices of women's health politics were transformed. The practices moved away from protest campaigns and decentralized exchanges between mostly

voluntary activist groups toward policies of dialog with the population establishment and a focus on UN processes. These policies were increasingly coordinated by professionalized gender experts. This trend was accompanied by pressure to find common political positions among quite different groups, and with the population establishment itself, and to develop pragmatic strategic approaches accordingly. The political program of women's health groups working internationally, thus, moved away from a protest against population policies; this program was, of course, connected to more general critiques of the state and of social structures as a whole. Indeed, the original political goal of many within the international women's health movement had been to integrate anti-racist, anti-eugenic, anti-imperialist, and critical analysis of technologies into the feminist project.

In contrast, the position initially articulated collectively by the women's voices group through the "Women's Declaration of Population Policies" (cited in Sen et al. 1994: 32) was that population programs were a neutral field of intervention, and thus it was possible to strive within this field for recognition of minimum standards of women's rights and health and demand that women's organizations should be allowed to participate within it. Despite a heated debate within the international women's health movement, this strategic proposal guided the women's dialog with the population establishment before and during the ICPD and became clearly visible in the process of negotiating *the* women's health agenda. After Cairo, this proposal, which had initially been presented merely as a strategic position of negotiation, framed the general agenda of established gender and health NGOs. Within this agenda, reproductive rights and health (and subsequently sexual health and rights as well) became the main framework of social analysis, with gender as its only category. Issues—such as a political critique of the research, development, and distribution of contraceptives and sterilization methods, given that they are the core technologies of population policies, and critique of the racist and utilitarian ideological fundamentals of neo-Malthusianism—that had been central to the international women's health movement became more and more marginalized. These changes initially provoked a lot of conflict within the international women's health movement, which was still present at the ICPD's NGO Forum.[23] After Cairo, there has been more and more separation of political spheres by issues and spaces, and

a disconnected coexistence of different agendas. At the Cairo Plus Five conferences, for example, the space of NGO participation was coordinated and dominated by the "women's voices" group (then called HERA) and did not include any critical positions opposed to pursuing gender policies within the framework of population policies. Those who were still critical of demographic strategies and their core technologies left the UN arena or were marginalized within it. After Cairo, they concentrated instead on other strategies of alliance. For example, WGNRR started to engage with the People's Health Movement (Nair 2001) while the Committee on Women, Population, and Environment cooperated with critical ecological movements and anti-racist groups in the US to confront neo-Malthusian anti-immigration agendas (Silliman and Bhattacharjee 2002; Silliman and King 1999).

The gender and health lobby, which had reached the status of "experts" within the population establishment as a result of the consensus of Cairo, has concentrated on the following activities:

1. elaborating programmatic strategies and concepts within the sexual and reproductive rights and health framework;
2. monitoring national population policies (international agencies are now mainly left out of evaluation and control); and
3. elaborating and implementing reproductive health services themselves.

The space they have conquered within population programs can be seen as an "add-on" approach. The programs, now called reproductive health programs, are not restricted any longer to the distribution of contraceptives and sterilization. These services are, nevertheless, still at the core of most population programs, but other reproductive health services which were part of Cairo's Programme of Action have been included, albeit as additional elements. In this sense, they illustrate a division of labor within the population establishment since Cairo: conservative, private population agencies still concentrate on providing family planning services, while women's NGOs, as service providers and designers of new program concepts, concentrate on innovative elements of reproductive health—for example, treatment of reproductive tract infections, post-abortion care, programs against domestic violence—or

aim to provide family planning to new target groups, such as adolescents, sex workers, or men.

In my view, to understand these transformations, it is not sufficient to look just at a change of power, indicated by a new leadership within the international women's health movement, or to interpret them as the result of the movement's co-option by the population establishment. Nor can these changes be interpreted simply as the result of NGOization, professionalization, and the increasing dominance of Northern gender experts, as might be suggested if one looks only at those who initiated the "women's voices" program, that is, the IWHC's "population femocrats". Instead, more complex processes of hegemony construction around the frame of reproductive and sexual health and rights have been at work. In my view, three conditions were important for that change of hegemony within the international women's health movement.

First, there have been important differences across continents and countries in the experiences of women's health movements with population programs. It is not incidental that the central supporters of the "women's voices" agenda were not only US American but also Latin American feminists. Their experience was of anti-natalist population programs that had *not* firmly taken root in government policies, and of continuing pro-natalist policies backed by military, nationalist, and Catholic agendas. In addition, feminist movements focused on state-oriented gender policies had gained in confidence during the late 1980s and early 1990s as many Latin Americans overthrew long-standing (military) dictatorships and opened toward democracy. In Asian countries, in contrast, feminist movements had for decades contended with long-standing and well-established state-led population programs that were invariably huge, authoritarian, and repressive. It was these movements that lost some of their influence in what became an international gender NGO aristocracy. These continental differences—especially between Asia and (Latin) America[24]—have remained to this day. For instance, at the 2002 International Women and Health Meeting held in Toronto, Canada, the critique of neo-Malthusian strategies and population policies was marginal, while in Delhi in 2005, one important focus was "the politics and the resurgence of population policies".[25]

Second, the transformation of the international women's health movement is not a result of the social and regional background of its

protagonists and should not be reduced to a matter of identity politics. The transformation is also the result of a change from movements holding a political theoretical position based in anti-state, anti-eugenic, anti-imperialist, and anti-racist convictions toward holding a more liberal perspective that focuses more clearly on gender differences although integrated within socialist or social democrat analyses.

But these theoretical and regional differences and transformations represent overall trends within which, of course, there are many exceptions. There have been, for example, disagreements and conflicts among Latin American feminist networks about the acceptance of population policies, while prominent Asian feminists, such as Gita Sen, promoted the "women's voices" agenda and participated in HERA. There have also been many feminists who moved between the two currents, given that the boundaries between them have been never closed or fixed.

These ambiguities illustrate that the processes of constructing hegemony within population policies encompassed nearly all the strands of the international women's health movement, except for those protagonists who distanced themselves clearly from the Cairo consensus at the outset; many of them subsequently left the political terrain of international population policies altogether. Many feminist organizations became involved in this agenda after making a strategic evaluation that supporting the framework of reproductive and sexual health and rights within population policies was a positive step forward, even though they still criticized population policies per se. After all, as German feminist researcher and journalist Christa Wichterich commented, critiques of the Cairo consensus did not present any equally successful counter-concept to the conceptual frame of reproductive rights (Wichterich 1994: 149). That is, the central reference point for the "women's voices", and subsequently HERA group, was women and health, not an anti-population policy movement. The concept of reproductive rights put the principle of self-determination and bodily integrity into the center with gender as the central category of analysis. But the women's voices project simplified and reduced these principles, and disconnected them from their broader critical context, thereby making it possible to articulate them within the framework of population policies, to which many within the international women's health movement had previously been antagonistic.

The third condition for the change of hegemony within the international women's health movement, and a reason why it was able to develop sufficient cohesion for the new project, was the fact that important protagonists (or "organic intellectuals" as Gramsci would call them[26]), who did not represent or support a liberal pragmatic policy but rather broader critical projects, still engaged in this change. One important example was the network Development Alternatives with Women for a New Era (DAWN), which aims to represent disadvantaged women from the South. For DAWN, the options of being reduced to liberal perspectives dominated by Northern feminism or ignoring socio-economic differences and becoming distant and removed from grassroots social movements were no options at all. Another example was the involvement of the US theorist and activist, Rosalind Petchesky, whose critical work on the role of the state in policies of procreation and whose history of activism in movements against anti-natalist programs within the US gave important credibility to the "women's voices" agenda. These intellectuals made important conceptual contributions to the revision of the "old" critique of population policies, which were assimilated by the post-Cairo population project.

DENIAL OF DEMOGRAPHIC OBJECTIVES AND "POST-CATASTROPHIC" REFORMULATIONS

An important contribution of the women's voices agenda to the hegemonic project of post-Cairo population policies was their interpretation of the very goal of population policies. They either denied that such policies had any demographic aims at all, or they redefined the term "population policies".

One habitus of mainstream gender NGO policy since Cairo is that proponents declare that demographic objectives in international population programs are irrelevant, immaterial or, at least, vanishing. Coordinator of LACWHN, Amparo Claro, for example, declared that population policies were an "outmoded issue" to which only those women's groups who "cling to the past" would pay attention (Claro 2002). Rosalind Petchesky has declared that neo-Malthusian strategies have lost their influence

since Cairo (Petchesky 2000: 16) and described feminist positions against population policies as being "old discussions . . . off the point" (Petchesky 1999). In Petchesky's opinion, the real problem is neo-liberal strategies of restructuring health care systems. She interprets, for example, UNFPA's 1999 campaign highlighting the scandal that world population had reached six billion people not as expression of neo-Malthusianism but as tactical propaganda reminiscent of old rhetoric that no longer represented UNFPA's real agenda (ibid.).

Other networks, such as Women's Environment and Development Organization (WEDO) (a US-based NGO that organized the women's caucus at the ICPD and accompanied the international women's health movement during the 1990s) and DAWN, tended toward these inter-pretations as well in the conclusions they drew from their country monitoring studies of the ICPD's Programme of Action implementation (Correa 2000; DAWN 1999; WEDO 1999). The reports suggest that, in many countries, there has been only "semantic" reform of population policies since the ICPD; for instance, substituting the term "family plan-ning" with "reproductive health" in program titles, but still concentrating on distributing long-lasting contraceptives and carrying out sterilizations, priorities that continue to be backed by international donors. However, DAWN and WEDO explain these phenomena and the neglect of reform toward more integrated services for women's health as a consequence of "institutional inertia" or a "lack of conceptual clarity" within the Cairo language itself (DAWN 1999; WEDO 1999). Such interpretations do not allow questions to be raised about either the continuities in anti-natalist demographic strategies or their transformations. These interpretations simply declare an unquestionable assumption that these strategies have lost influence and ground since Cairo. Furthermore, these interpretations suggest solutions based on the technical expertise of NGOs operating within state institutions or frameworks instead of analyzing social forces and motives behind the politics of reproduction.

When one evaluates the actual policies of international donor agencies, however, it becomes clear that the demographic project of reducing world population growth has not really lost its influence at all. "Popula-tion stabilization"[27] remains an explicit core goal of the family planning programs supported by USAID, the most powerful financial donor for population programs worldwide whose position remains unchallenged

(USAID 2005). Likewise, the second most important donor, the World Bank, declares "population stabilization" to be an "unfinished agenda" for its Health, Nutrition and Population Sector (World Bank 2005). It becomes obvious that important criteria to measure the success or failure of reproductive health programs have remained the contraceptive prevalence rate[28] and the total fertility rate:[29] the trend of the first should be upwards and of the second, downwards. The unaltered key position of these indicators can be explained only by the demographic core of population policies.

But what has changed in post-Cairo population policies is the transformation to a "post-catastrophic" (Jahn and Wehling 1998) form of neo-Malthusianism. The post-Cairo project formulates the world population "problem" in far less aggressive and far more sophisticated and complex terms than before. Instead of population growth being portrayed as the main cause of poverty or environmental destruction, for instance, it is described as just one factor among many in creating social crises, albeit a factor of both cause and effect.[30] Such apparently unquestionable formulations have contributed to silencing discussion of previous political controversies, such as the heated debates during the 1970s as to whether population growth is a cause or consequence of underdevelopment. "Postmodern" discursive strategies that no longer talk in terms of "either/or", but in terms of "and/and" or "not only/but also" reflect a hegemonic situation in which the construction of the population problem is no longer questioned but is acknowledged as a complex issue. The sophistication of demographic knowledge is also visible in the programmatic strategies of large population agencies such as the World Bank and UNFPA, which tailor their national strategies according to a country's age structure, "stage of demographic transition", or relative weight claimed for three demographic factors: "unwanted fertility", "wanted fertility", and "population momentum" (Bongaarts 1994). On the basis of this "knowledge", they are elaborating different strategies for different target groups and designing different "method mixes" for different countries (World Bank 1999b).

Nevertheless, these fragmentations of factors and target groups are still based on a neo-Malthusian assumption of superfluous populations, underpinned in turn by utilitarian and racist assumptions. Knowledge production in demography principally stems from the idea of abstract,

quantitative statistical correlations between a given population and given resources, and from the idea that the optimum size of a population can be calculated and thus the population in excess of this optimum size can also be calculated (Heim and Schaz 1996; Hummel 2000). This utilitarian approach is combined in the neo-Malthusian argument with the racist, biopolitical idea of identifying certain specific populations to represent (albeit in an abstract way) the superfluous quantity of people that has already been calculated (for example, a population excluded from access to resources such as sustainable cultivatable land). The translation of abstract superfluous quantities into actual groups of people is the logical leap inherent in neo-Malthusianism, which can be described as its specific racism. Foucault has analyzed such a logic as a selective biopolitical act—making life in general or the life of all people or the life of the planet dependent on the death (or exclusion from procreation) of some—a racism less based on traditional eugenic ideas of superior beings and more on social Darwinian notions of fighting the poor rather than poverty (Foucault 2001).

Not only is this theoretical base still valid; for population policies it is re-emerging as an economic argument maintaining that population growth and economic growth are interdependent variables—a knowledge production that had been largely discredited by leading economic studies during the Cairo process and afterwards (for example, Cassen 1994). Recent UNFPA reports revive the notion that there is an ideal population age structure, and that countries in a certain stage of demographic transition (for instance, few old people but decreasing birth rates) have a "demographic bonus" (for example, UNFPA 2002).

An analysis based only on the micro level of individual body politics and on the isolated category of gender does not provide the means to perceive and criticize these utilitarian and racist foundations of demographic knowledge production. The emphasis on gender, disconnected from any analysis of the management of populations, has contributed to this blind spot in the hegemonic discourse that declares that demographic objectives are no longer pursued or relevant. Ultimately, gender concepts ignore completely the motives for population programs but concentrate only on the methods they employ and how strategies to manage populations are translated into body politics, as Stephen Sinding, Director of Population

Sciences at the Rockefeller Foundation and a central protagonist of the Cairo consensus from the population establishment has pointed out (Sinding 2000). Sinding argues that, since the ICPD, the *why* of anti-natalist strategies is no longer a controversial issue in international politics, as it was two decades earlier during the 1974 UN population conference in Bucharest. The idea that world population growth simply had to be reduced was so well established that controversies switched to the *how* of population programs, a switch that pushed issues of body politics to the fore.

REDEFINING POPULATION POLICIES AND ANTI-NEO-LIBERAL SOCIAL POLICIES

Apart from this denial of the macro level goal of demographic strategies, the mainstream discourse of gender NGOs has become tied to an analysis that no longer refuses biopolitical state intervention in general. Indeed, it even interprets population policies as a positive project opposing a supposed neo-liberal dissolution of statehood as a field of "smooth" international social policies that should be reinforced so as to oppose neo-liberalism. The subtext of redefining population policies in this way is an analysis that interprets neo-liberalism as a threat to (biopolitical) statehood rather than as a means of its transformation. In these definitions, population policies become a generic term for social policies, handling issues of procreation, sexuality, and mortality or even for *all* political programs aiming to enhance the well-being of the population. These redefinitions have been promoted especially by Latin American feminists and by the DAWN network of Southern women. In an ICPD preparatory meeting in 1993, Latin American women's health NGOs opted in favor of population policies "that are programmed, developed and carried out with social justice and equality" (LACWHN 1993: 89). One of DAWN's experts on population policies, Gita Sen, reinterpreted the history of feminist positions in this way in her book entitled *Population Policies Reconsidered: Health, Empowerment, and Rights* (1994). Sen explains that feminist critique had tried to "recast population policies and programs" in order to "recast development objectives"—but omits to mention that

the mainstream of women's health movements in the 1980s had been questioning the state's regulation of populations in general. Her strategy of redefinition is to declare "that population is not an issue just of numbers, but of complex social relationships that govern birth, death and migration" (Sen 1994: 69). Rosalind Petchesky saw this redefinition as adequate as well, arguing that "there is no logical necessity for population policies to be elitist, reductionist or aimed only at reducing numbers". She proposed the following redefinition: "Given a different kind of vision, demographers and population planners could just as well apply their tools to identifying and eliminating inequities in these patterns of distribution" (Petchesky 2000: 21).

These redefinitions reflect the strategic orientation of mainstream gender lobbyists toward extending population management rationalities beyond health-oriented programs. With the demand that national population policies be established as inter-sectoral institutions coordinating social policy, they aim to promote elements of the Cairo Programme of Action that are not directly health oriented, for example, empowerment programs for women or gender justice. Interestingly, a review of Sen's book, published in *Population and Development Review*, one of the leading journals of the population establishment, argues that this feminist vision strengthens interdisciplinary state-led population policies.

> Curiously, the contributors appear to be unaware of the contradiction between their denunciation of centralized and authoritarian family planning programs and the highly statist prescriptions for government intervention that emerge in many of the chapters. (McIntosh 1994: 655)

Separating a "good" population policy as social policy from a "bad" neo-liberal decomposition of the state hinders an analysis about the possible articulations between neo-Malthusian and neo-liberal rationalities. On the theoretical and conceptual level, neo-Malthusianism is based on a state project that does not promote equality of distribution, redistribution of resources, or social justice, but instead adapts the variable population to the social status quo and the given economic order. The UK-based social justice group, The Corner House, which collaborated with WGNRR in analyzing the current deployment of international neo-Malthusianism, characterized this fact with the phrase: "Scratch a free marketeer and underneath you'll find a neo-Malthusian."[31]

But it is not only at the level of conceptual basics that the redefinition of population policies in opposition to neo-liberal policies produces blind spots. For example, many groups say they face a dilemma between criticizing the World Bank for initiating neo-liberal health sector reforms and defending it as one of the world's largest financial funders of reproductive health programs. But the dilemma as to which course of action to pursue has been formulated in a way that isolates neo-liberal policies from population policies and that therefore limits understanding of the interconnections between the two.

As more and more movements become critical of globalization, the mainstream women's health NGOs and networks are becoming themselves more vocally critical of the world economic order, using the critique as a base for a rapprochement between different women's health networks in order to protest against neo-liberal reforms of health care systems (Nair et al. 2004; Petchesky 2003). But a critique of health sector reforms in the context of reproductive health policies is insufficient if it looks only at the decomposition of public and state-led services and does not ask about the dynamics of restructuring them. Why are certain services prioritized more than others in international health policies? Studies of current trends in reproductive health policies show that, in the dominant approach to health sector reforms, public health policies are reduced to "essential or basic health packages" for the poor that focus particularly on family planning (and increasingly on HIV/AIDS) while other public health care services are privatized and cut back (Evers and Juárez 2002; Petchesky 2003: 158).[32] Women's activist and critical US academic Betsy Hartmann describes these trends as follows: The Cairo consensus "rationalizes the continuing assault on public health by prioritizing family planning over reproductive health, and reproductive health over primary health care" (Hartmann 2002: 274). This trend is confirmed by an OECD study which estimates that from 1990 to 1998 international development aid allocated 34 percent of its health spending to population policies and only 30 percent to basic health services. The trend has been more marked since the Cairo conference: from 1996 to 1998 population funding accounted for 40 percent of health aid compared to 30 percent for basic health services (OECD 2000).

To analyze these imbalances, it is necessary to go beyond reinterpretations of population policies to examine the anti-natalist bias of reproductive health policies.

THE ANTI-NATALIST BIAS OF
REPRODUCTIVE HEALTH POLICIES

The promotion of women's individual reproductive health is probably today the most important discursive element of the hegemonic post-Cairo agenda. The introduction of epidemiological language has been fundamental not only to legitimize and explain population programs but also to enable them to develop in accord with the women's movement's focus on health problems. The successful articulation and combination of epidemiological, demographic, and emancipatory discursive elements has been another productive contribution of mainstream gender NGO policies to the new hegemonic project of population policies since Cairo.

A 2004 publicity campaign by the German Stiftung Weltbevölkerung (World Population Foundation) illustrates the results of this contribution. To commemorate a decade of Cairo's Programme of Action, the Foundation, together with the German government's aid and development agency, Gesellschaft für Technische Zusammenarbeit (GTZ), ran the campaign under the slogan "Safe Motherhood". As part of the campaign, a short film was shown in cinemas across Germany with the title—and key message—"contraception can save lives". The film showed a woman somewhere in Africa working on dry and barren land with not a hint of vegetation anywhere in sight. Then a huge flock of storks flies threateningly over her head . . .[33]

In the post-Cairo agenda, becoming pregnant has become a life-threatening "reproductive risk". The focus on reproductive health makes an individual solely responsible for what happens to her body. This can be seen as positive or progressive as it overturns notions of regarding women only as part of a couple or a family and of considering them with all their reproductive capacities as directly responsible for the fate of a nation, economic development, or the protection of the environment. Such responsibilities are replaced within neo-liberal rationales by individual responsibility for one's own reproductive health and by the idea of rational self-management to accomplish adequate "reproductive behavior". Epidemiological data offer criteria as to why certain women at certain times of their lives should *not* have children for the sake of their reproductive health; it offers the articulation of multiple arguments but within anti-natalist objectives. The concept of reproductive health—a

concept that once expressed on different levels the objections and protests of women's health movements against many of the practices of family planning programs—has been depoliticized by its reformulation as the administration of reproductive risks. The demand for reproductive health came about in part because of the abuse of women's health, especially because some contraceptive methods neglected or harmed women's health. The population establishment, however, was able to absorb and deflect this critique by translating it into the goal of "quality of care". But the term reproductive health had also been introduced in order to expand services beyond the isolated offer of contraceptives and to integrate a wider range of women's health services into population programs, a goal that was an integral part of the Cairo Programme of Action. Besides aiming to treat and prevent reproductive tract infections and sexually-transmitted diseases, including HIV/AIDS, the Programme of Action declared that population programs should provide better assistance to women during pregnancy and delivery. Indeed, after the ICPD, the large population agencies began to emphasize combating maternal mortality, estimated by WHO as the cause of over 500,000 deaths annually.[34] At first glance, this emphasis on maternal mortality seems to indicate a containment of anti-natalist objectives because it promises not only to respect the right *not* to have children, but also the right of access to appropriate health-care services that will enable women to have a safe pregnancy and childbirth (Par.7.2. of the POA).

However, the maternal mortality discourse is in fact articulated as a key component of anti-natalist strategies using a set of epidemiological risk calculations. The Safe Motherhood Initiative, a coordinated campaign of the large donor agencies involved in population policies,[35] regards that intervention is required at three levels to prevent maternal mortality:

1. prevention of pregnancy;
2. prevention of complications during pregnancy; and
3. appropriate management of any complications that might occur (WHO 1999: 29).

Clearly family planning is an integral programmatic part of the first level of intervention in campaigns against maternal mortality—following the simple logic that a woman who is not pregnant cannot die because

of the consequences of pregnancy. This argument is based, on the one hand, on the undisputed logic that the risk of a woman dying during her lifetime of pregnancy complications (the so-called lifetime risk) can be generally reduced by decreasing birth rates without improving health care (UNFPA 1999a: 9).

But, above all, safe motherhood programs focus on manipulating specific factors that increase the risk of maternal mortality and that are believed to be responsive to responsible individual reproductive behavior. "Self-determination" in this risk calculation is framed in a normative way: risky reproductive behavior is categorized as being pregnant under the age of 19 or over the age of 35; having less than two or three years "birth spacing" between pregnancies; and having too many pregnancies (more than three or four) "Unplanned and poorly timed pregnancies" become an "obstacle" for safe motherhood (World Bank 1999b: 43)—and behavioral changes are proposed to enable women to avoid pregnancies "that are too early, too late, or too frequent" (WHO 1999: 23).

Given this focus, it is not surprising that those programatic elements of the Safe Motherhood Initiative's agencies that are in fact engaging in obstetric care and in treating and preventing complications that arise during delivery (Maine 2000) are generally given a low-ranking priority in population programs. For example, the World Bank itself admitted in 1999 that only in 40 percent of the countries (29 of 77) in which it supported a safe motherhood program did the program include a safe delivery component (World Bank 1999b: 9) A study of USAID concluded that "USAID's efforts in the area of reproductive health still tend to add pieces of reproductive health to family planning programs rather than place family planning in a larger reproductive health context" (Forman and Ghosh 2000: 12).

The interpretation that these developments indicate a medicalization of population policies (Halfon 1997; Qadeer 1998), however, does not make clear that the extension of epidemiological arguments into population policies is not medicalization in the sense of the expanded power of biomedical knowledge or of the institution of medicine (Lupton 1997). Medicalization needs to be understood here as a process of translating different kinds of information about not only the biomedical condition but also the psycho-social or socio-economic conditions of health into a knowledge resource that the individual has to use in order to manage

her reproductive behavior most efficiently, that is, in order to find the most adequate way of adapting herself dynamically to given social circumstances (Greco 1993; Lemke 2000). Epidemiologic studies about high-risk pregnancies (for example, teenage pregnancies) indicate not only biomedical causes of risk (for example, a small pelvis) but also different social conditions ascribed to the risk group (for example, unsafe abortions or reduced access to health services). Generally, these forms of knowledge production, based on statistical correlations, allow for very different interpretations of the correlations. They provide opportunities for their articulation within social or emancipatory gender policies as well as within conservative ones and within demographic strategies. But they individualize social problems by attaching them to an individual body as a risk calculus and, therefore, focus on an individual's preventive behavior, and not directly on the social causes of the social problem behind the risk.

Normative formulations of "risk-reducing" practices have been absorbed by gender experts. They use epidemiological arguments to show the relationship between reproductive health and the social organization of sexuality, reproductive health, and domestic violence, and then introduce these arguments into population debates. But, as two influential feminist lobbyists and architects of the Cairo consensus, Adrienne Germain and Ruth Dixon-Mueller, have demonstrated, they also refer to the demographic (anti-natalist) effects of enhanced reproductive health in order to introduce their issues into the field of population policies (Dixon-Mueller and Germain 2000).

Germain and Dixon-Mueller describe the intention of the "women's voices" project as "broadening and deepening the interpretation of the 'population problem' and proposing a more holistic agenda for action" (ibid.: 70). They make it clear that they believe there are two conditions for articulating gender issues within population policies and do so by referring to epidemiological knowledge. First, limiting women's self-determination is valid in the population field only when it can be supported by epidemiological categories from the field of health; for example, when violence against women is correlated with higher rates of unsafe abortion or with more complications during pregnancy. Second, the demographic effects of tackling domestic violence—above all, a reduction in unwanted pregnancies—provide the necessary and decisive justification.

This epidemiologic and demographic foundation of the struggle for (reproductive and sexual) self-determination reduces and limits coercive social structures to what the authors call the "coercive pro-natalism of everyday life" (Dixon-Mueller and Germain 2000: 70). Other coercive social structures that prevent women from having children systematically fade into the background in these biased approaches toward reproductive health.

Articulating issues of violence against women and unwanted pregnancies in a context of reducing and preventing reproductive risks by using family planning fulfills an important function in the population establishment discourse. The post-Cairo discourse forestalls the interpretation that norms about the "right" timing and spacing of pregnancies could be interpreted as, in fact, limiting women's freedom of choice and decision-making. In its description of problematic pregnancies, it repeatedly combines the adjectives "mistimed", "poorly timed", or "ill-timed" with the adjective "unwanted". The World Bank goes further and equates all the adjectives when it defines "unwanted fertility" as "births from pregnancies that were poorly timed or unintended" (World Bank 1999a: 8). Planning a pregnancy—and planning it in conformity with the lowest possible reproductive risk—becomes the precondition for being "wanted". Such an equation shows that the principle of self-determination is no longer the precondition for policies to be considered successful, but implies the "right style of conduct" that results from implementing a rational health care behavior on the basis of "behavioral changes".

TEENAGE PREGNANCIES, POPULATION MOMENTUM, AND NEO-LIBERAL SECURITY TECHNOLOGIES

Sometimes the post-Cairo discourse undermines the official separation between the macro and micro level aspects of population policies and links the calculation of reproductive risk groups directly to demographic aims. This is especially true for policies aimed at adolescents. Here, population agencies combine epidemiological arguments directly with demographic calculations. On the one hand, they argue that preventing teenage pregnancies helps to reduce maternal mortality—they calculate that girls aged between 15 and 19 years have a two to four times higher risk

of dying as a consequence of pregnancy than women aged between 20 and 30. But, on the other hand, they link the reproductive health programs of young women directly to so-called population momentum. Demographers define population momentum as the effect of growth in population despite a drop in fertility rates. This happens because women entering into "reproductive age" were born when fertility rates were higher, and thus they have more children, albeit fewer children than their mothers.[36] Therefore, in many countries, the population establishment expects greater demographic effects by delaying births in younger generations than from simply aiming to reduce birth rates. UNFPA explains: "The population momentum can be slowed significantly if young people are enabled and encouraged to have children later in life" (UNFPA 1999b: 4). The World Bank warns that: "In many countries, fertility rates have fallen for older, married women. But there is an epidemic of unwanted pregnancy and unsafe sexual practice among youth" (World Bank 1999a: 3).

Of all the articulations of anti-natalist strategies as reproductive risk management that pathologizes pregnancies and births in the countries of Asia, Africa, and Latin America, the discourse of "too early" pregnancies is the one in which most resources have been invested in recent years. The Safe Motherhood Initiative declared at a conference where it elaborated its programmatic strategies that its first "action message" was to delay first sexual activity, marriage, and first birth (Starrs 1997: 20ff). The focus on young people, backed by demographic arguments connected with epidemiological ones, has resulted in an explosion of programs for adolescents. Ana Maria Pizarro, a physician and Nicaraguan women's health activist engaged in international women's health policies, evaluates the trend as follows:

> I think they invest in the young generation because they expect more demographic effects from this than from investments in women. Ten years ago it was still possible to finance projects for women's health—that has become much more difficult. But now the main focus is to assist adolescents and to do advocacy work for the access of young people to contraceptives—if you do that you will find money. (Pizarro 2002)

Preventing teenage pregnancies can be connected, of course, with very different political projects. On the one hand, women's health organizations use the issue and the resources that go with it to strengthen adolescents'

access to contraceptives and sexual education, and to limit parental rights over them. Youth programs also coincide with the interest of social movements that are paying more attention to young people. But, on the other hand, the programmatic effort to reduce teenage pregnancies is also linked to conservative policies promoting sexual abstinence for young people or condemning sex out of wedlock, strategies that have gained in strength in recent years through the influence of the US government as the most important donor for population programs (Hendrixson 2002; UNFPA 2004b: 98).

Without denying this heterogeneity of political and programmatic articulations, it has to be emphasized that the demographic strategies of the population establishment still remain at its core and provide the main motive for these policies. This becomes obvious when the establishment prioritizes programs for adolescent health in those countries in which "population momentum" is considered a problem. In its "strategy matrix", for example, the World Bank distinguishes between different contraceptive method-mixes for different countries according to the prevalence of demographic factors for population growth. In many sub-Saharan countries, the Work Bank evaluates the "desired family size" as too high and regards it as the main problem, and thus focuses on expanding contraceptive use and changing reproductive behavior more generally; adolescents are of little interest to them. But in countries such as India or Bangladesh or Latin America, the main problem is deemed to be population momentum and therefore adolescents are considered more important (Merrick 1999; World Bank 1999a).

Gender experts have adopted this instrumentalization of adolescent reproductive health for demographic purposes. For example, when the Director of the IWHC, Adrienne Germain, poses the question of how Bangladesh is to continue with its "success story" of increasing women's use of contraceptives, her answer is to address the needs of different targets groups more specifically by a broader reproductive health approach. This approach, she says, would

> . . . be more cost-effective in meeting demographic goals in at least two ways: First by reducing contraceptive dropout and failure rates, and second by appealing to the younger individuals and couples who, in demographic terms, need to delay sexual initiation and marriage, and contracept earlier and longer. (Germain 1997: 33)

What becomes obvious in these different articulations of demographic and epidemiological strategies within either emancipatory or conservative political programs is that the population policies since Cairo have to be interpreted not just as morally or politically consistent and universal, but also, and above all, as policies that, as Michel Foucault has interpreted them, are "security technologies" (Foucault 2001). This interpretation means that strategies of normalization distinguishing between different target groups and different circumstances are deployed in order to develop specific biopolitical approaches with the hope that they will give the most effective results.

In a study on expert discourses about teenage pregnancies in South Africa, researchers Catriona Macleod and Kevin Durrheim believe that the focus of this knowledge production is not to produce absolute criteria but to operate within a range of more or less optimal variations.

> The optimal mean in terms of adolescent sexuality is abstinence from sex. However, sexual intercourse and even pregnancy lie within the acceptable bandwidth, but carry with them a different set of management tactics than does non-coital behaviour. Put simply, if the teenager is a virgin, there is the danger of the desire for sex, and thus sexuality education programmes recommend "say no". If she is sexually active, there is the possibility of pregnancy, and thus programmes extend their input to the use of contraceptives. (Macleod and Durrheim 2002: 54)

The focus of the Safe Motherhood Initiative on adolescents is similar when it subdivides the world into countries or regions with or without the prevailing practice of sex before marriage and then proposes different strategies based on this differentiation—specific family planning services for young people in the former countries or raising the legal age for marriage in the latter (Starrs 1997: 22ff).

These examples show that post-Cairo policies work though different epidemiological risk categories and conceptual strategic approaches, but are nevertheless linked to a single demographic (anti-natalist) strategy that determines the distribution of resources and the relevance of human rights approaches. Sociologist Robert Castel once described these technologies as a new "neo-liberal" form of managing populations while increasingly differentiating them through the calculation of risk factors (Castel 1983: 68ff).

CONCLUSION

A gender political agenda framework that ignores these biopolitical strategies and constellations cannot analyze critically the broader picture of current population policies, the anti-natalist bias of reproductive health strategies, and the dependency and instrumentalization of resources for gender political programs based on these calculations. This does not mean that the actual services derived from these strategies are always problematic. But it does have several repercussions and implications. First, it oversees the normative power of interpellating individual self-responsibility and self-management of reproductive behavior and excludes women who do not assimilate these norms by characterizing them as not empowered, not self-determined, and as exhibiting risky behavior. The increasing ignorance of the medicalized international agenda of gender policies toward these anti-natalist biases, norms, and pressures is reviving a maternalist approach of "knowing better what is good for Other women", an approach that was once so clearly opposed by the reproductive rights agenda.

Second, the mainstream gender and health agenda has no means of understanding neo-liberal health sector reforms and their impact on reproductive health policies as a project not directed against neo-Malthusian statehood but as a project of reforming and restructuring it.

There is a lack of data and knowledge production about the international distribution of resources between family planning, broader reproductive health, and basic health care. There is also a lack of analysis of the anti-natalist bias of international health policies that have been produced by this mainstream framing of NGO policies.

An isolated category of gender does not help in understanding the transformation of demographic strategies because it remains at the levels of the "how" of population policies and of individual body politics. A feminist critique that goes beyond mainstream NGO policies has to come back to the analysis of the utilitarian and racist selective foundations of demographic knowledge production. And it has to acknowledge that this knowledge production necessarily operates with numbers and the idea of superfluous populations. It must not hide this fact behind euphemistic interpretations of the term "population policies".

These limitations of current gender and health policies explain, in my opinion, why the international NGO community had no language or instruments with which to react adequately to the late 1990s sterilization campaign in Peru. A precondition of these medicalized and euphemistic interpretations of the new hegemonic population project post-Cairo has been a process of hegemony building within the international women's health movement itself. These processes have a background in complex constellations between continents, political experiences, and agendas, and in "organic intellectuals" contributing to the integration into the bio-political project. There is no easy position to adopt from which to oppose this new hegemony—but it is certainly time to question many false assumptions, blind spots, and normative strategies that made the consensus of Cairo possible. Such questions would help to raise issues about the biopolitical anti-natalist project as a whole.

NOTES

1. It was subsequently revealed that the program had been designed, encouraged, and monitored at the highest levels in Fujimori's government, including the president's office.
2. In June–July 1999, the UN General Assembly convened a special session, ICPD+5, known as "Cairo Plus Five", to review progress toward meeting the ICPD goals. It was preceded by a series of roundtables and technical meetings, including an ICPD+5 forum in The Hague, The Netherlands, in February 1999, which was attended by governments and NGOs.
3. The sterilization campaign ended after publicity in the international press, especially in the United States. Grover Joseph Ress, a member of the subcommittee on International Operations and Human Rights of the House Committee on Foreign Affairs, published a report of a staff delegation visit to Peru (US Congress, February 10, 1998), which was picked up by the *Washington Post* (February 12, 1998) and *New York Times* (February 15, 1998). But the use of quotas and sterilization festivals stopped with no official acknowledgment of the practices.
4. A fact-finding report *Nada Personal* by feminist lawyer Giulia Tamayo was supported by the Center for Reproductive Law and Policy based in New York and by the Latin American women's rights network, CLADEM (Tamayo 1999).
5. This chapter analyzes the Cairo Programme of Action and population "talk" since Cairo as a new hegemonic project of population policies that integrated feminist paradigms, such as reproductive health, rights, and empowerment, but did not abandon the biopolitical demographic program of controlling and regulating population numbers at the macro

level. Feminist concepts were reformulated and integrated into the project in such a way that anti-natalist strategies were not questioned. Indeed, they were legitimized, albeit in a way different from before.

Italian political theorist Antonio Gramsci is renowned for his concept of "hegemony" as a means of maintaining the state in a capitalist society. He argued that a social project becomes hegemonic when it can articulate to itself elements of other class or group projects, such that it appears as the embodiment of the interests of the nation. Capitalism, Gramsci suggested, maintains control not just through violence and political and economic coercion, but also ideologically, through a hegemonic culture in which the values of the bourgeoisie became the "common sense" values of all. Thus a consensus culture develops in which all people identify their own good with the good of the bourgeoisie, and help to maintain the status quo rather than revolting against it. In Gramsci's view, any class that wishes to dominate in modern conditions has to move beyond its own narrow "economic-corporate" interests, to exert intellectual and moral leadership, and to make alliances and compromises with a variety of forces. A nexus of institutions, social relations, and ideas reproduce the hegemony of the dominant class.

6. My argument, and the focus of this chapter, concerns the hegemonic project within the population establishment in the second half of the 1990s after the 1994 Cairo meeting. This hegemonic project, anchored as it is since Cairo in gender and health conceptual paradigms, has been challenged since the year 2000 to some extent by the conservative US Bush administration and by the Millennium Development Goals that marginalized the concepts of reproductive health and rights. Nevertheless, I believe that these frames are still valid within the international donor community, although it is adapting itself to the increasing importance of HIV/AIDS and to the backlash against gender policies.

NGOization means that activism or social movements change their structures to become more formal, institutional, and professionalized. Previous struggles are converted into "projects".

7. The most important national development agency in the population field is USAID. Important multilateral agencies include the UNFPA, the World Bank, and the World Health Organization. Important private foundations are Rockefeller, Ford, Mellon, Hewlett & Packard, MacArthur, and Pathfinder Fund International. Important think tanks are the Population Council and the Population Reference Bureau. An important supra-organization of private family planning organizations is the International Planned Parenthood Federation (IPPF). All of these comprise a knowledge network closely-linked on both personal and professional levels. Most are based in the United States (Hartmann 1995, 2002).

8. A term coined by the US-based network "Committee on Women Population, and Environment" (CWPE 1999).

9. This contradiction was made obvious at a UNFPA installation during the 1999 Cairo-Plus Five Conference held in The Hague, which depicted a huge number six followed by nine just as huge zeros to illustrate the estimated annual growth in the world's population. Yet within one of the huge zeros were the words: "Population is about people, not about numbers."

10. I use the term "statehood" because I want to emphasize that the "state" does not refer to a narrow concept as simply the apparatus of state institutions, but rather to the state as the condensation of social relationships with specific forms and functions (Jessop 1990; Poulantzas 2002). This is the base from which I talk about the state or statehood in relation to the terrain of international population policies, referring to the concept of an "internationalized state" (Borg 2001; Hirsch 2000; Sauer 2003).

11. Neo-Gramscian refers to a theoretical leftist approach to state theories and to international policies that emphasize the role of hegemony building. It includes study of the role of NGOs in the processes of hegemony building (Borg 2001; Gill 1993).

12. "Corporatist" refers to the large institionalized systems of representation in Fordist states, such as labor unions, the state itself, political parties, and associations of employers that managed or negotiated conflicts and were regarded as legitimate representatives of the masses.

13. This refers to the increased impact on the policies of nation-states of international strategies, macroeconomic policies, multinational corporations, and multilateral political institutions.

14. The term "NGO-ization of social movements" seems to have been coined by Sonia Alvarez and refers to a process that tends toward the development of a professionalized group of conference entrepreneurs, who become more distant from the concerns of locally based activists. Alvarez described an NGO boom of the 1990s which was marked by a region-wide shift *away* from feminist activities centered on popular education, mobilization, and poor and working-class women's empowerment and a move *toward* policy-focused activities, issue-specialization, and resource concentration among the more technically adept, transnationalized, and professionalized NGOs within the feminist field. As a result, some states and inter-governmental organizations began to turn to some feminist NGOs as "experts on gender" rather than as citizens' groups advocating on behalf of women's rights. Alvarez concludes that it has become "increasingly difficult for Latin American feminist NGOs to maintain the delicate balance between movement-oriented contestatory activities and their expanding technical-advisory relationship to donors, States and INGOs [International Non-Governmental Organizations]" (Alvarez 1998).

15. For example, USAID provided half of IPPF's budget at the beginning of the 1970s (Warwick 1982: 45). Political scientist Amy Higer points out that this policy of using indirect private channels for financial aid gave more power to USAID's Population Office, the central coordinator of such funding, compared to other areas of foreign aid that were organized in a more decentralized manner (Higer 1997: 345).

16. In 1974, the National Security Study Memorandum, a study commissioned by Henry Kissinger about the relevance of international population growth, urged the US government to "minimize charges of an imperialist motivation behind its support of population activities" and to resort to resources from "other donors and/or from private and international organizations (many of which receive contributions from AID)" when there was a "lack of strong government interest in population reduction programs" (cited in Mumford 1994: 146).

17. For a summary of some of these traditions, see Ross (1998).
18. Political scientist Bob Jessop explains this concept of strategic or state selectivity as follows:

> Its differential impact on the capacity of different class (relevant) forces to pursue their interests in different strategies over a given time horizon is not inscribed in the state system as such. Instead it depends on the relation between state structures and the strategies which various forces adopt towards it [. . .]. Particular forms of state privilege some strategies over others, some time horizons over others, some coalition possibilities over others. A given type of state, a given state form, a given form of regime, will be more accessible to some forces than others according to the strategies they adopt to gain state power. And it will be more suited to the pursuit of some types of economic or political strategy than others because of the modes of intervention and resources which characterize that system. (Jessop 1990: 10)

19. "Pass through" refers to the concept of strategic selectivity and the idea that states have the power to allow certain policies to become stronger or to pass through within the image of selectivity.
20. See Ross (1998) for how population ideology has been used by different interests over time, suggesting its malleability or suitability as a strategy.
21. The Amsterdam meeting was conducted as a tribunal against population control policies, and was the fourth International Women's Health Meeting (IWHM). The first IWHM meeting was held in 1977 in Rome, the most recent, the tenth, in 2005 in New Delhi. These meetings have become one of the largest gatherings of women's health advocates, academics, funding institutions, and other women's networks involved in women's health and reproductive rights. The purpose of the meetings is to exchange knowledge, experience, and ideas among women working in self-help health, and to serve as a venue for women's health activists from around the world to gather in order to take stock of the gains and setbacks in the area of women's health and reproductive rights.
22. HERA describes itself as "an international group of well known women's and human rights activists for which the IWHC served as the secretariat". Its mission is

> . . . to ensure implementation of the agreements reached at the International Conference on Population and Development (ICPD) . . . and the Fourth World Conference on Women . . . held in Beijing in 1995. Following our collaborative effort to help generate the Cairo and Beijing consensus, we decided to continue to work together to advocate, and help design and implement strategies to guarantee sexual and reproductive rights and health, within a broader context of human rights and sustainable development. *See HERA Mission Statement*. Available online at http://www.iwhc.org/index.php?option=com_content&task=view&id=3396&Itemid=824. (Accessed on October 19, 2009)

23. For example, anti-population politics feminists organized an "International Public Hearing on Crimes against Women related to Population Policies". The organizers of

this hearing emphasized that the ICPD was based on a continuity of a neo-Malthusian crisis diagnosis: "The ICPD will promote false analysis that poverty, migration, and environmental degradation are caused by 'overpopulation'. We, the organizers of the public hearing, reject this analysis and prescription, and challenge the racist, eugenic, and interventionalist ideology of such analysis" (Anon 1994).

24. African feminists have often stressed that they too have been generally marginalized within the international women's health movement. They have not had such experience with population programs because most of internationally-driven anti-natalist programs have been established in Africa only since the 1980s as part of the IMF's Structural Adjustment Programs. The focus of African groups and individuals often cut across the other "continental priorities", demanding more emphasis on wider social and economic structures of inequality and their impact on women's health policies.

25. Continental differences can be identified when comparing the monitoring reports of how countries were implementing the Programme of Action that several NGO groups prepared for the Cairo Plus Five conference. The Latin American and Caribbean Women's Health Network (LACWHN) does not mention the demographic rationales behind international women's health policies at all (LACWHN 1998). But the Malaysian network, ARROW, concludes the following from its study of eight South-Asian countries: "Population policies remain demographic-centered and target-oriented in terms of quantified goals, and have not shown any shift towards more people-centered development" (ARROW 1999: 12).

26. Gramsci distinguished between a "traditional" intelligentsia that sees itself (wrongly) as a class apart from society, and the thinking groups that every class produces from its own ranks "organically". Such "organic" intellectuals articulate the feelings and experiences that "the masses" cannot express for themselves.

27. A population has "stabilized" when the number of births equals the number of deaths, with the result that, aside from immigration, the size of the population remains relatively constant. It is said to occur when fertility reaches "replacement level" (considered to be 2.1 children in industrialized countries) over a period of time. Since Cairo, "population stabilization" is increasingly used instead of "population control" or "population reduction" to stress the voluntary nature of the actions sought.

28. That is the ratio of women either married or in stable relationships who, or whose partners, are using a "modern" contraceptive technology.

29. That is, the average number of children women would have under the current conditions.

30. A typical example of this type of language is paragraph 3.1. of the Programme of Action:

> There is general agreement that persistent widespread poverty as well as serious social and gender inequities have significant influences on, and are in turn influenced by, demographic parameters such as population growth, structure, and distribution. There is also general agreement that unsustainable consumption and production patterns are contributing to the unsustainable use of natural resources and environmental degradation as well as to the reinforcement of social inequities and of poverty with the above-mentioned consequences for demographic parameters. (UN 1994)

31. See Lohman (2005).
    Malthus never intended his *Essay on Population* to be an exploration of the mysteries of human fertility: rather, it was a polemic in defense of private property and a strategic theory designed to assist private interests get hold of community land—the forests, fields and pastures that villagers held and managed in common—and the labor that survived on it. See Hildyard (2005).
32. For example, the World Bank's "Basic Health and Nutrition Project", which was part of its health sector reform strategy between 1994 and 1999, imposed a clear focus on the distribution of family planning as one of only three criteria for the coverage of health services (World Bank 1997).
33. Storks have long symbolized fertility in European culture, being associated with springtime and with birth. In some areas, it is thought that the stork can cause a woman to become pregnant merely by looking at her.
34. Maternal mortality includes all deaths in the context of pregnancy, either because of complications during pregnancy or (in most cases) during delivery. It also includes deaths from unsafe abortions (WHO/UNICEF 1996).
35. The members of the Safe Motherhood Initiative, founded in 1987, are the World Bank, UNFPA, UNICEF, WHO, the Population Council, and the International Planned Parenthood Federation.
36. "Population momentum" is defined in demography as the tendency for a given population to increase in numbers, even if replacement level fertility has been achieved, because of the (high) number of women in their childbearing years. Such momentum means that the population continues to grow for several generations before stabilizing.

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9

Structural Adjustment, Impotence, and Family Planning: Men's Voices in Egypt[*]

KAMRAN ASDAR ALI

Sharif Arafa's 1996 Egyptian film *Al Nom fil asal* (*Sleeping with Honey*)[1] opens with a wedding celebration, followed by a scene in the newlyweds' bedroom—and then by the groom's suicide. His widow later explains to investigators how, despite their effort at foreplay, her deceased husband remained "unaroused". She theorizes that he may have taken his life to avoid confronting his sexual dysfunction.

The film's central character, the chief of police investigation for Cairo,[2] returns to his office after investigating the groom's death and finds the waiting area full of men and women fighting each other—the women are upset at their husbands' lack of sexual vigor. That same evening, he returns home to celebrate his wedding anniversary and tries to make love to his wife, but does not succeed. The next day, he orders an official survey of those city districts reporting domestic disturbances and finds that upper-class, middle-class, and popular neighborhoods are all reporting being afflicted with this mysterious problem. From here on, impotence as a form of cultural shame becomes central to the film's narrative structure as it plays on the constructed arguments of Arab manliness and its links to sexual prowess.

Seeking to find the cause of this affliction, the chief of police eventually consults an eminent physician, who asserts that the lack of sexual ful-fillment for men and women could lead to widespread hopelessness, clinical

depression, and the malfunctioning of the human body, leading to further social disorder and chaos. The cause of the affliction, he maintains, is because people in Egypt are constantly exposed via mass media to lies and misinformation by the political establishment.

The physician's voice of reason and science depicts mass impotence as a result of the manipulation of people's will, and the chief of police's acceptance of this suggestion becomes a metaphor in the film for the lack of democratic voice within Egyptian national politics. The protagonist now seeks to cure this alienation of people's bodies and minds and ensure a more orderly resolution to the threat of disorder through the process of consciousness raising. At the end of *Sleeping with Honey*, the chief of police leads a group of chanting men in a procession—they have found their voice through his persuasion—toward the People's Assembly (the national parliament) and accosts a group of parliamentarians and ministers to pay attention to the people's plight.[3]

I invoke the film here as a reminder of the similarities between its various themes, and arguments put forward by national agencies like the USAID, multilateral agencies like the World Bank and the International Monetary Fund (IMF) and affiliated development agencies of the United Nations about civil society and democratic freedom popular in the Egypt of the mid-1990s. I use it to evaluate and detail the impact in Egypt of the inter-nationally subsidized development agenda, coupled as it was to the privatization of key industries and with economic liberalization. Much like the international agenda, the film's message selectively criticizes certain state ministries and senior bureaucrats, yet fails to mention the dismantling of the welfare state and its impact on people's living condition. Taking my cue from *Sleeping with Honey*, I argue that the emphasis of political reform over questions of social and economic equity fits neatly and comprehensively into the neo-liberal agenda propagated by Egypt's international donors and its funded (NGOs) during the 1990s. This agenda risked friction with Egyptian state functionaries to pursue its de-velopmental aspirations, yet also collaborated with it to push its own economic goals of structural adjustment and fiscal constraint.

Building on the film's portrayal of male impotency,[4] this chapter critically evaluates the internationally-funded development agenda in Egypt and its emphasis on family planning as a key developmental

strategy for Egypt's future economic and social well-being. It relates the relationship this process holds to the economy and to the NGOs that have become the conduits of international aid and supervise the developmental agenda (a role analogous to that played by the chief of police in the film). The family planning program contributes to and expands on arguments about the body, fertility, and sexuality that are so pivotal to the message that the film sought to portray. Within this context, the film's depiction of men's anxieties surrounding sexual inadequacy prompts me to focus on the attention paid to men's behavior in fertility decisions by the Egyptian family planning program.

The film's representation of impotence assists me in arguing that the liberalization of the Egyptian economy in the last two decades has produced sets of winners and losers. Besides the multitude of urban and rural poor, the career civil servant, the *muwazzaf*, the epitome of Egyptian modernity and state patronage, became a threatened species as the state, under international pressure, shrunk the size of its bureaucracy. Guarantees for new state jobs for university graduates were systematically eroded as the progressive social contract of a welfare state faded in the 1980s.[5] My critical reading of the film elaborates upon the theme of how structural changes in Egyptian social and economic life have affected society's productive/reproductive abilities.

The film also allows me to examine ethnographically its central trope, the representation of Arab masculinity. Recent discussions of Middle Eastern and Mediterranean masculinity have retained their conceptual affiliation with the concept of honor and thus with notions of virility, fearlessness, moral strength, and structured violence (See, for example, Abu-Lughod 1986; Caton 1991; Ghoussoub and Sinclair-Webb 2000; Gilsenan 1996; Herzfled 1985). These descriptions subscribe to a large degree to idealized and hegemonic notions of masculinities (Lindisfarne 1994: 82–96). An important rethinking of these constructions comes through looking at how a plurality of gendered identities emerges through an investigation of social practice.[6]

Based on my fieldwork,[7] I revisit the issue of impotency in Egypt, so graphically depicted in Arafa's film, and broaden the argument to show its occurrence not only due to lack of political freedoms, but also as a direct consequence of social and economic deprivation, specifically of the working poor, the real victims of the structural adjustment-dictated

privatization policies. I argue that as much as the fear of "impotence" and sexual dysfunction persists among the Egyptian poor (symbolically, metaphorically or otherwise), its cure may not lie only in the liberal notions of giving voice, as envisioned by the protagonist in Arafa's film, but also in a more comprehensive and sustained attention to social and economic inequities.

THE ECONOMY AND FAMILY PLANNING

During my first few days in Cairo in the early 1990s, I tried to initiate a conversation with a taxi driver to practice my colloquial Egyptian dialect. I asked whether he had an opinion on the family planning program. The taxi driver responded slowly but with perceptible anger in his voice. He said he was a commerce graduate from the Ain Shams University in Cairo and drove the taxi because he was unemployed, which meant he did not have a job in keeping with his university degree. He lived with his wife and two young children in his parent's two-room apartment in a poor neighborhood of the city. "The problem is not overpopulation", he said, rather the problem was the wrong priorities of the state. God had promised Muslims that he would provide for them. Not to trust God was forbidden in Islam, he argued. "The Egyptian state is diverting resources by importing cigarettes and opening up hotels for people to drink alcohol while the money could be used to open up projects [*mashruaat*] to employ people", he added angrily.

The taxi driver's anger, although couched in the language of Islam, was also a clear response to the effects of the structural reform of the Egyptian economy that the Egyptian state was implementing in the early 1990s under international pressure. In May and November 1991, the IMF and the World Bank negotiated a Standby Agreement and a Structural Adjustment Loan with the Government of Egypt, a package that together makes up the Economic Reform and Structural Adjustment Program (ERSAP). These agreements extended the Open Door policies of the mid-1970s and pushed for further institutional changes in the Egyptian economy to make it more market oriented (Khalek unpublished MS). In the 1990s, unemployment levels remained high, with university and technical institute graduates making up 65–75 percent of the unemployed. Although official figures

reported unemployment at 8–10 percent, other estimates ranged from 15–20 percent of an Egyptian workforce of almost 18 million (Pfeifer 1999). Recent fluctuations in exchange rates and the devaluation of the Egyptian pound in early 2003 make it clear that even after 12 years of IMF regulated "bitter pills", the Egyptian people continue to suffer the consequences. For example, along with rising inflation that is unofficially at 12–14 percent, unemployment levels may rise higher as more state owned enterprises are privatized along with a retrenchment of workers.[8]

The population program in Egypt[9] needs to be understood as a corollary to these changes in the Egyptian economy. A 1989 USAID report painted a picture of Egyptian social life by describing how urbanization had caused loss of agricultural land, universities could not absorb more students, the government's capacity to employ graduates had diminished, and gross domestic savings had declined (Gillespie et al. 1989). A reduction in the population's size was a solution to reduce development expenditures. This reduction would eventually put less pressure on the state to provide for education, health care, and jobs in the future.[10]

In the 1980s and 1990s as international development agencies, like the USAID, compelled the Egyptian state to rationalize its economy, privatize its assets, and remove social subsidies,[11] they also provided the largest subsidies for population control. These agencies asserted that a reduction of state support would increase the cost of supporting many children and persuade families to adopt family planning as a "voluntary and non-coercive" choice. Just as the IMF-sponsored structural adjustment policy in the early 1990s was supposed to cut excess in the economy, so the family planning program was presumed to guarantee a correspondingly lean family. Playing on the imagery of surplus and waste, the structural adjustment program and the population program in Egypt should be considered together as methods to streamline the social and economic corpus of Egypt.

NON-GOVERNMENTAL ORGANIZATIONS AND FAMILY PLANNING

In Egypt over the last 20 years, there have been positive increases in individual income and in other developmental indices. Yet, the gradual

removal of welfare structures and state subsidies for food, education, and housing have adversely affected the economic well-being of the rural and urban poor. Within this social and economic framework, Egyptian NGOs funded by international donors play a vital role in propagating ideas about self-help and personal responsibility. These NGOs primarily, like any-where else, employ educated men and women from the urban middle and upper professional classes. Motivated by a development agenda of "social good", some of these groups conduct research seeking to trans-form the "unmodern" living habits of the peasantry and the urban poor. It is this class allied with the state in most circumstances (represented by the chief of police's position in the film) that takes upon itself the civilizing project of the post-independence nation-state, attempting to incorpor-ate the populace through pedagogy and consciousness raising into a unitary nation.

Keeping this background in perspective, the internationally sponsored family planning and development initiatives in Egypt funded many NGOs with women and development components in the 1990s.[12] These NGOs generated debates within Egypt on internationally defined positions on women's reproductive rights. Under the auspices of the Population Council, Ford Foundation, USAID, and the UN agencies, such groups along with other activist women and secular women's groups organized seminars and wrote position papers on reproductive health-related issues of women's individual rights and autonomy. International literature on reproductive health supports the role of such NGOs as crucial in making governments comply with international treaties on women's emancipation and also to the acts of discrimination that effect women's status in different countries (Cook 1993; Toubia and An-Na'im unpublished). Hence, some women's groups and NGOs, as pressure groups, bridged the gap between international legal standards and the Egyptian state's position on these issues. In such instances, these formations remained within the parameters of the debate set by the larger agenda of international development. By speaking the language of liberal democracy, and in their quest to make the Egyptian state conform to international rules and forms of conduct, these groups became interlocutors for the international donor agencies. Such arguments clearly questioned the sovereignty of the Egyptian and other Middle Eastern states by advocating the supremacy of international standards. They inevitably also became sites of tension between the Egyptian state bureaucracy and international donor agencies.

Despite these frictions, many NGOs participated along with government agencies in family planning and other development projects. Liberal-minded Egyptian scholars have argued that civil society in Egypt has a pivotal role in achieving the goals of the population program, because rivalry among government ministries and the resultant bureaucratic inertia make the state unable to do so (Ibrahim 1995). Civil society institutions, therefore, needed to be strengthened for substantial improvement to occur in development goals, which include family planning.[13]

But donor agencies were highly selective in their funding choices. USAID, in particular, largely supported NGOs that echoed its priorities and that became the conduits through which the internationally sponsored family planning program sought to establish itself outside the realm of governmental control. Transfer of technology, training of competent local staff, family planning research, family planning service provision, and private sector distribution of contraceptives are some of the fields in which these Egyptian NGOs worked under USAID supervision.[14]

The Contraceptive Social Marketing Project (previously Family of the Future), for example, was allocated US$12 million between 1988 and 1993 to market contraceptives through the private sector to lower and middle-income Egyptian couples (USAID 1992). Another NGO, Clinical Services Improvement Project, budgeted for US$13 million for the same period to establish 112 upgraded fee-for-service family planning clinics in different governorates (ibid.). Similarly, the Egyptian Young Medical Doctors Association was given US$2 million dollars for a five-year period to recruit doctors in private practice for family planning training and to establish private clinics as extensions of the family planning services.[15]

Most such NGOs remained ideologically committed to family planning and to the related structural adjustment program. A senior member of the Egyptian Fertility Care Society, an NGO that works primarily in the area of research and evaluation of contraception, told me that contraceptive use should precede a focus on economic growth if a rapid fall in fertility rates is desired. My informant stated that structural adjustment policies and the removal of social subsidies would benefit the program, because they would force people to realize the costs of having a large family. A clinical staff member of the Cairo Family Planning Association (a pioneer NGO in the family planning field since 1977) informed me that, along with cultural grounds and the low social status of women, a major

reason parents did not desire a small family was due to some of the existing social subsidies guaranteed by the state.[16] Only removal of this support would make families aware of the real costs of raising children.[17] In short, the positions of many NGO members on family planning were part of a worldview that they shared with the international donors.

MEN'S INVOLVEMENT IN FAMILY PLANNING

In Egypt the family planning program, through its pedagogical and other efforts, not only seeks to reduce population size, but also introduces notions of individual choice and self-regulation (Ali 2002). The primary target of the family planning program in Egypt, as elsewhere, is the female body, although the male body is not ignored. In the last decade, international family planning policy has paid special attention to the multiple forms in which different cultures organize fertility decisions and has moved planners to consider the views of male partners regarding fertility control.[18] After investigating men's views, planners seek to overcome the perceived threats from "traditional" men to the family planning program through a concerted media campaign to educate and inform men of the importance of family planning. International family planning efforts have successfully integrated male methods, such as condoms and vasectomies, into their various programs. In Egypt, however, the user rates for these methods are extremely low. Policymakers explain this failure partly by evoking traditional culture, patriarchal norms, native notions of maleness, the "backwardness" of the peasant population, and "Islamic doctrine". Men's involvement is based on the premise that, although men may not use contraceptives themselves, they should be persuaded to allow and enable their wives to accept and use contraceptives.

Some NGOs have used cultural perspectives to influence Egyptian men's fertility behavior patterns.[19] In the summer of 1993, I attended a week-long workshop called the Family Health Week organized in Minya, an Upper Egyptian governorate, through the collaboration of Johns Hopkins University Population Communication Services (funded by USAID) with the Egyptian National Population Council, the Ministry of Health and 16 local family planning and information, education and

communication (IEC) organizations. The program comprised outreach activities, seminars, evening meetings, church and mosque meetings, and small community meetings aimed at promoting general awareness about family planning.

In developmental rhetoric, Upper Egyptians are thought to be culturally and politically more conservative. Although most of the country's development projects are based in this region, development experts argue that traditional behavior patterns in the region are difficult to change. The Health Week was designed to motivate Upper Egyptians to modify their negative attitudes toward accepting family planning and allow their spouses to use contraceptives.

During the week, I accompanied religious leaders and doctors to a nearby village where a lecture was arranged for men on the benefits of fertility control and the conformity of Islam to family planning. When we arrived after sunset, there were about 20 men present at the primary school building. The *shaykh*, an important person among local leaders, started speaking in the glow of kerosene lanterns. Using Egyptian non-classical Arabic, he argued that Islam was not against having children, "but the children should be healthy and educated". He asserted that a physically, morally, and intellectually unhealthy nation would be undesirable in Islam. He added that the present deteriorating economic circumstances would force large families into dire social conditions. Hence, family planning was necessary to avoid a bleak future. He gave graphic examples of how too many children could also affect the health of the mother. "We could imagine", he continued showing his theatrical skills, "how a mother may have two babies suckling on her two breasts while she is already pregnant with another child".

During the question and answer session that followed, one of them asked why, since women had started taking pills, they now had more twins and even triplets and thus, were endangering their lives? The *shaykh* responded with annoyance and admonished the crowd that these rumors were spread by the uneducated and the idle. Raising his voice, he said, "The people should only trust the doctor while discussing birth control and its effect on the body, for they have the scientific knowledge."

This episode reflects how local level NGOs work with the Ministry of Health and international donors to create consent and argue for the legitimacy of scientific method for family planning. It also shows how

the questioning of the state message was firmly dealt with, not by polite persuasion or counseling, the preferred methods in family planning literature (Population Reports 1987), but by condemning local knowledge as rumor-based and by reasserting the authority of the speaker. State planners and international donors also had mutually shared concerns on the success of their program. For example, using the *shaykh* to deliver the message to men aided in offsetting arguments against family planning from religious leaders belonging to the oppositional Islamist movement.

At this time of the early 1990s, the governorate of Minya was a hot bed of Islamist resistance to state authorities. At the time of my research, there were daily armed attacks on police convoys by Islamists. In exchange, the security services would be involved in search and destroy missions in the countryside.

This political situation itself had its effect on the outcome of this Health Week. The organizers had produced a play aimed at male participation in family planning, which was scheduled to be performed at several sites. The script of the play had been pre-approved by the government censors and the security apparatus as having no politically "objectionable" material. The actors were also considered politically "trustworthy", meaning they were not sympathetic to the Islamists. Yet on the day of the first performance, the Governor of Minya, an army general, canceled the play, even though the Health Week activities were part of the government sponsored development program for the region. Given the violent skirmishes between the state forces and the Islamists in the area, assembling a large audience was considered a security risk by the Governor's office. The international sponsors of the program protested to the higher authorities in Cairo, but were politely told to follow the regional government's orders. The political system, with its heightened concerns of maintaining law and order, became a hindrance to the propagation of the state's own policy initiatives, leaving the foreign donors and their locally supported NGOs frustrated and incapable of completing their goals. Two kinds of responses to the potential of "disorder" were at play here. One was that of the state seeking to crush all opposition through acts of brute force. The other was that of civil society forces seeking to mitigate backwardness through pedagogical techniques.

This example echoes the friction in *Sleeping with Honey* between the film's protagonist, the chief of police, and Egypt's political elite as he tries

to reason with his superiors to take the affliction of impotence seriously and help people out of their misery. Similarly, the international donors and their funded NGOs faced predicaments in the implementation of their program. States like Egypt have yet to develop the administrative and ideological apparatuses that lead to creating "free subjects" (Asad 1992). Therefore, force and coercion still take precedence over techniques of persuasion and pedagogy as methods of managing populations, methods favored at least rhetorically by the NGOs. Although the program closely followed the politically progressive arguments on consent and choice in determining family size, the localized implementation of this agenda remains enmeshed within the political and social power of the lending agencies and the Egyptian state. In essence, the liberal desire to understand men's perspective remains subservient to the goals of the family planning program. If people's health had been the Health Week's primary focus, then the emphasis should not have been only on consciousness raising, but also on alleviation of poverty and the socio-economic problems of the community which are responsible for most disease conditions.

REPRESENTATION OF MEN

As the film metaphorically connects to male anxieties about their sexual function in rapidly deteriorating economic conditions, it also symbolically connects the lack of people's participation in public life to the suppression of men's voices, illustrated clearly in the final scenes of the film when the chief of police leads chanting men in a procession. Even with its critically attuned message, the film has a gendered argument that potentially divides political and public space in to inside/outside, public/domestic, and male/female arenas. This argument works within the framework of parliamentary states that tend to delegate relatively more power to men through family law, tax law, and inheritance law and through encouraging differential power of men over women in the labor markets (Gal 1997).

The emphasis on the loss and retrieval of primarily men's voices in Arafa's film is not dissimilar to an effort made through the family planning program to reconstitute the man's role within the Egyptian family.[20] For example, the Egyptian family planning program sponsors a series of television advertisements, produced by the State Information Services

under technical guidance and financing from USAID and Johns Hopkins University, that address the issue of men's role in contraceptive decision-making. The advertisements attempt to make men aware of their familial responsibilities as providers. Some of them represent men as heads of families, yet simultaneously criticize them as defenders of the status quo, as conservative, traditional, and anti-modern—that is, anti-birth control. Others encourage men to be flexible and uncritical toward women's decisions to use contraceptives. Some summon men to behave better toward their womenfolk, showing images of modern urban men helping their wives in domestic household chores. The advertisements are geared toward convincing Egyptian men to act as "real men", that is, being more responsible individuals—and hence produce fewer babies.

Ironically, the head of the household's responsibility to provide for their families and contribute toward the social good is emphasized at a time of general economic instability for the Egyptian poor and of rapidly-diminishing opportunities to fulfill that role. By concentrating on issues of birth control, the internationally sponsored family planning program deflects resentment against the state onto the domestic sphere, as couples with large families are themselves held responsible for the economic plight in their lives. On the one hand, these advertisements seek to encourage socially responsible fathers to follow the state's advice on family planning and restrict their family size. On the other, the high unemployment rate, socio-economic deprivation, and the undemocratic political environment push most people to the margins of the system, creating political conflict and deep resentment.

One of the major concerns of the family planning program is to create a progressive, positive, and modern family space devoid of pressures from other kin, friends, and relatives in reproductive decisions. There is an assumption that the household is a decision-making unit, free and open to discussion regarding fertility choice and the sole locus of social respectability. In liberal political theory, the family is regarded as the natural basis of civil life. As a location of biological ties and affective emotions among its members, it may, however, stand opposed to the workings of the liberal state. Family can be "thus simultaneously the foundation of modern state and antagonistic to it" (Pateman 1989). Hence, the family needs to be reconstituted on modern grounds. Its allegiance has to reside with the state linked, as it is, to the ideology of social good. Therefore,

the Egyptian state may still need the father as the head of the household, but a new kind of patriarch who is subservient to the state and responsible about his civil duties, duties that include enabling the state to have access to women's bodies for contraceptive purposes without hindrance from their male partners.[21]

This focus on behavioral change is also theoretically connected to the notion of the self-regulating individual. Liberal thought does not consider individuality as a foundational given that political institutions can regulate. Rather, it is a process of coming-to-be, a constructive agenda through which the individual is fashioned. A picture of liberalism that incorporates the ethical individual with collective rights and governmental restraint may be proper, but we need to also pay attention to liberalism's underlying fear of libertine excesses and human passions. People need to be taught to control their desires and learn to curb "natural" instincts in order to become self-disciplined and disciplining individuals (Mehta 1992). Egypt, as a modernizing state, utilizes the family planning program as a pedagogical project (similar to the chief of police's project in the film) to create such a self-regulating population (with responsible, subservient and disciplined fathers). Of course, as the construction of the "new" self becomes the focus of persuasive techniques to create responsible men and women, so economic pressures simultaneously create conditions to curtail reproduction.

How do men themselves give meaning to the language and practice of fertility control as it enters their households and affects the notions of their bodies, fertility, and sexuality? How do social and economic changes reinforce or destabilize their positions by impinging on gender relations within the household?

MEN'S ANXIETIES

Among communities in the low-income residential area of Behteem, an outlying neighborhood to the north of Cairo where numerous textile factories and public housing estates were established in the 1950s and 1960s,[22] impotence and sterility destabilized men's positions, as perhaps elsewhere in Egypt as well. Periodically people blamed impotence on curses and magic (*sehr*) by rival men. I would constantly hear stories of

how some men were tied (*marabout*), and rendered impotent by magic performed by some *amil* (magician) in the service of some enemy. For men, the sexual act was also connected with their procreative ability. Sterility was considered shameful enough for men not to go to doctors and they considered a semen analysis a humiliating experience.

Attar or herbalists were very popular in these urban neighborhoods. Men and women both went to them for a variety of ailments. They deal with a range of male sexual problems of sterility and impotence. One *attar* told me about the different herbs and their healing effects on men's loss of sexual drive and impotence. Men would also tell me of commonly used natural oils that decreased sperm count. Cottonseed oil (*zeit il kafoor*) was rumored to be used by the military in preparing food for the male recruits ostensibly to control their libido and perhaps their ability to reproduce. Such conspiratorial stories expose men's anxiety over losing their sexual potency, yet may also hint at peoples' resentment of a state seeking to curb their procreative abilities.

Men often did not use condoms because they complained that they did not receive, and were incapable of giving, sexual pleasure (Ali 1996, 2000). These men insisted that women received heightened sexual pleasure when they felt the ejaculation passing through their vagina into their uterus. This pleasure was mixed with the gradual cooling down of female bodies from a hot state. Moreover, there was a general consensus among my informants that women take longer to reach orgasm. Men sometimes took medications to maintain sustained erections, so that they could help their wives reach sexual climax. Several pharmacists in urban and rural areas showed me anti-depression medications that were popular with men because they had priapic side effects, giving men a painful yet prolonged erection. Men would also buy local anesthetic sprays for the same purpose.

Women may have different constructions of pleasure, but as a man, I could not explore their ideas to the same extent. Nonetheless, men's concern with their spouse's orgasmic pleasure indicates a sense of sharing and giving sexual pleasure. Yet seldom does literature on gender in the Middle East address the issue of affection among husbands and wives and how bonds of mutual support and caring are constructed within households. Most studies take unequal gender relations as a given, rarely questioning how they are maintained, perpetuated, or changed in linkage to the social changes in society.[23]

Thus, men's concerns about sexual performance may also pertain to worries about their ability to sustain prolonged erection. Local notions of sexuality are linked to popular interpretation of Islam that encourages sexual relations not only as a procreative act, but also as something to be enjoyed by both sexes. Yet there is room here for subtle forms of social control. As women are constructed as wives, mothers, and daughters within systems of prestige with various ideological underpinnings, there is a competing construction of woman as an essentialized over-sexed figure.[24] In an earlier era, women could be secluded to contain their social threat, but now with changing societal norms women are able to transverse in mixed environments in densely populated cities (Ghoussoub 2000: 231). Thus, men's emphasis on female orgasm may have reflected their fear about "unsatisfied" women seeking others to fulfill their needs.[25]

Anxiety over a spouse's infidelity made some men restrict their wives' movements and also at times led to extreme forms of domestic violence. On the one hand, this fear exposed the popular imagery of women as over-sexed and unfaithful. On the other, it pointed toward a construction of competing masculinities where men fear other men with more erect penises as potential rivals for their women. Impotence, therefore, becomes an extreme insult. An erect penis and its power to satisfy are directly linked to the rhetoric and practice of power that men believe is needed to control women.

SOCIAL LIFE AND MEN'S SEXUALITY

The economic pressure people faced during the mid-1990s in neighborhoods like Behteem made them socially vulnerable. With a decrease in social subsidies, food expenditure within households has substantially increased in the last 10 years. This has led many households whose spending on food accounted for more than three-quarters of their bills to cut their food consumption significantly. People in urban poor neighborhoods stopped consuming meat and their main nutrient intakes were staples like bread and beans. These processes in turn influenced calorie supply and food intake of the poorest sections of society. In addition, even after adjusting for inflation, real wages by 1990 had gone down by 5–7 percent since the mid-1980s (Ferghany 1991; Handoussa 1991). With unemployment and

rising poverty, the state considered places like Behteem in the mid-1990s as politically volatile areas. The state felt threatened by the possibility of urban oppositional movements related to the Islamist groups recruiting in these communities. This was the official reason given for the heavy policing of these areas by the local police and by security details of the intelligence services. Social unrest unleashed by the removal of subsidies and rising unemployment rates continuously created problems of law and order and civic management for the Egyptian state. The news media in Egypt was full of reports of the state's violent engagement with the Islamist groups as attacks on "terrorist violence". Seldom was there an analysis of the social and economic violence of poverty and the lack of amenities suffered by the Egyptian rural and urban poor.

The popular dimensions of this opposition were illustrated among a group of urban working class men in Cairo, who invoked the notion of a large powerful family, the *aila*, in linking themselves to larger group solidarities. This view became especially evident when these men spoke about the fertility control program in Egypt. In the early 1990s, the news from Bosnia was the most ominous for my rural and urban informants.[26] The perception of Muslims being persecuted because of their religion evoked anger and frustration among them. The situation in Palestine and the first *intifada* against the state of Israel also immensely affected them, more so because many of them were veterans of earlier wars against Israel. They interpreted these and other world events as discrimination against Muslims and took it as personal humiliation. For many, the internationally assisted family planning program was part of these series of events and of a larger Judeo-Christian plot to weaken the Muslims of the world. Ishaq, an urban informant, explained this further to me as follows:

> Allah is the creator, and the world belongs to him, then accordingly, the national boundaries are meaningless and the whole universe was created to be populated by Muslims. People should be allowed to travel, work and spread the message of Islam wherever they please. Therefore, it becomes a religious duty to enlarge your immediate family so that the larger family may become stronger.

These articulations point toward some important issues. Given a chance, most of my friends sought to travel as migrant laborers, primarily to escape the lack of good employment opportunities in their lives. Keeping

this background in mind, and the framing of their position in religious terms (similar to the taxi driver) notwithstanding, they deemed family planning as a contrived social issue. For, they thought, if they were allowed to travel, the world had enough resources to accommodate them. The imagery of a larger family and the critique of artificial geo-political boundaries simultaneously challenges the modern discourse on the geographical boundedness of nation-states. It also critiques the inter-nationally sponsored family planning program, based as it is on the thesis of limited assets within given borders of a nation-state, seldom arguing for international or local redistribution of resources.

The privatization of state industries has led to widespread layoffs and thus shrinking possibilities of employment in Behteem. As opportunities to earn a livelihood in the Gulf countries and in Iraq diminished after the 1991 Gulf War, people returned home to reduced chances of employment. Inflationary tendencies had, furthermore, made certain important food items, like meat, unaffordable for many. Such living conditions created pressures on men who were, most of the time, the only source of liveli-hood for families. My informants would speak of their inability to have pleasure in life if they could not provide a "decent" living for their families. To be laid off under these circumstances was catastrophic. Even those who held steady jobs as factory workers or low-level public servants spoke of their inability to provide for their families. Some of my luckier inform-ants held two or three jobs: working as a civil servant (*muwazzaf*) in the morning, driving a taxi in the afternoon, and selling home-cooked *tamiya* (*falafel*) at night. But they, like others, complained of a shortage of money. One of the less fortunate among my informants, Bilal, told me:

> I earn 100 pounds a month while working in a factory. I live in this room with my wife and four children. I share the toilet with three other families. My upstairs neighbours have nine people living in the same space as ours. Where should we go? Housing is so expensive. So is meat, I bought it today for 14 pounds a kilo. This is the only time we are going to have meat this month. There is no money left after all the other expenditures.

Further, as Bilal suggested, certain food products enhance the physical state of the body. For men, meat and meat products, in particular, were crucial energy-giving foods (popularly called *protienat*), and were essential to leading a healthy life and for sexual performance. Bilal added, "without

meat and with all these worries I ejaculate in a few minutes, whereas the rich man can keep his erection for half and hour, and satisfy his spouse". The inability to sustain a sexual act goes back to the imagery of not being able to control one's woman through prolonged sex. In relation to upper class men, rural and urban poor men generally consider themselves potentially more masculine, but poverty may be undermining these positive self-constructions. Unlike the portrayal of generalized impotency among all classes in the film *Sleeping with Honey*, my friends construct the rich not only as wealthy and fortunate but also more masculine as they can keep their women happy and provide for their families. Wealth and access to better paid jobs guaranteed a reduction of social worries and also the income to consume more meat products. My informants felt that poverty undermined their virility as men. As their sexual performance suffered, simultaneously their own standing as men suffered. Economic deprivation made them socially and physically impotent. In sum, poverty demasculinized them in their own eyes.

The social and economic deprivation of the Egyptian poor and the concomitant drive on families to curtail family size is experienced as a form of violence that socially castrates and humiliates the men with whom I spoke; in the process it also deprives them of their masculinity and manhood.[27]

In this global moment of New World Order, employment remains the only source of male dignity (Spivak 1996). As poverty levels increase in urban and rural areas, families struggle to manage under increasing adversity. Women are forced to seek employment outside their homes to help pay for the increasing costs of educating and rearing children. In urban areas, women from lower classes are seeking employment as domestics and as factory laborers. For men, their wives' excursions outside their household cuts through the rhetoric of idealized domesticity. Men grudgingly agree to their wives working because of the need for additional income. Yet they also complain that their spouses are neglecting domestic duties, including the proper training of the children. The fact that their partners need to work to support the household destabilizes the male roles as providers and challenges the man's authority within the family, further curtailing their productive/reproductive abilities.

CONCLUDING DISCUSSION

Development in the post-colonial era is linked to a teleological narrative modeled on histories that have already been experienced in the West. It becomes the self-representation of modernity for Third World states that aspire to bring the fruits of progress and innovation into the lives of their citizens (Gupta 1997). National governments such as in Egypt, armed with an anti-imperialist rhetoric in the 1950s and 1960s, did seek to create a debate on a path of development that was critical of Western impositions. Yet increasingly by the late 20th century, developmental initiatives linked to economic globalization meant the rationalizing and naturalizing of capitalism's power in progressivist terms, "as the engine that brings those on the bottom 'up' toward those who are already there" (Cooper and Packard 1997).

As this process gets related to representative democracy, liberal laws and the "free" market, it frames the legalistic arguments of rights and law as elements of political strategies that enable modernizing states to destroy old options and create new ones (Asad 1992: 334–36). Within this context, the international pressure on states like Egypt to comply with this production and management of "free individuals" and conform to international norms is sometimes exerted through the promotion of civil society.

The relationship between the social and the individual, and the relationship between the state, international organizations and those of its citizens, are mitigated through NGOs.[28] International development agencies and European–US governments celebrate internationally funded NGOs as the foundations to strengthen civil society in Egypt and as a counterpoint to the undemocratic and oppressive state.[29] This is a familiar refrain in the democratic politics of "lesser developed" nation-sates. But the role of civil society organizations in Egypt may also be linked to the neo-liberal international economic agenda.[30]

The transnationalization of global capital, moreover, requires a post-state class system. The process to strengthen international civil society assists the entry of global capital to organize the civil and legal boundaries of independent states according to its own prescriptions. The universalizing of a Western agenda through collaborative NGOs that

challenge the "rogue states" may increasingly be seen as a part of this universal civil society. It should also be reemphasized, however, that the argument of men's responsibility linked to choice in fertility control is made as welfare structures are being dismantled (also under international pressure) in Egypt, leaving families, especially women and children, more economically and socially vulnerable. This process of structural adjustment gets intrinsically connected to the push for universalized standards of law and rights as moves toward creating a civil society that guarantees political and cultural equity. By the late 20th century this move was "concomitant to the spread of markets, and it becomes identified with acceptance of social and economic inequity in the name of democracy" (Tsing 1997). The tensions, polarizations, and entanglements that accompany these processes across and within state boundaries shape new forms of historical categories or a "fragmented globality" (Trouillot 2001: 129).

The integration, albeit uneven, of global markets and media forms has no doubt produced universalized forms of consumptive desires. Yet social and spatial polarization inhibit the majority of Egyptians from satisfying those needs, producing conflict and tension. Despite the rhetoric of international agencies and of the Egyptian state, free market capitalism in Egypt has not been able to deliver the abstract cultural pleasures of freedom, democracy, and the ideal of citizenship. Rather, the state, sometimes in collaboration with international development agencies, has through public health campaigns, austerity measures, political violence, and police aggression coerced people to become more compliant with their fate.[31]

In one scene in the film, *Sleeping with Honey*, the chief of police delivers an impassioned speech, asking the parliament to consider the impotence epidemic seriously and think about a remedy. In a rhetorical mode, he argues that "if people have lost hope, then we should give them hope, and if they have forgotten how to sing, we should play music for them, and if it is a psychological problem them, we should look at its causes". Unless the state gives people hope, he pleads, people may not lead a natural and contended life. If this does not happen, he states, then people will continue to be fed myths and lies and will become a nation of donkeys that say yes to everything.[32] Like the protagonist in this film, Egyptian civil society organizations have periodically put forward an agenda of liberal political change and democratization. Some among these organizations have also

faced the full force of the state's wrath as a price for their criticism. Yet there has been at best a muted attack on the feasibility of the structural adjustment program and the related policy of economic liberalization. Keeping this in mind, that most Egyptians are not "sleeping with honey" or in any other kind of slumber: rather they are wide awake living the reality of social manipulation and economic oppression.

NOTES

1. In common usage, the phrase refers to people who are oblivious to their own un-satisfactory living circumstances.
2. The chief of police is played by the "six hundred pound gorilla of Egyptian [commercial] cinema", Adil Imam. Walter Armbrust has argued that prominent actors in commercial cinema are like texts themselves, texts that are conditioned by positions that the audiences take and by the audiences' association with the performer's previous roles. Commercial cinema audiences by and large view films through their actors, not their directors (Armbrust 1998).
3. *Sleeping with Honey* was popular in Egypt due partly to its critical message. It resonated well with the social mood of the day that was aspiring for a more open and pluralistic political system in Egypt. The question does arise, however; how did it pass the strict Egyptian censors? The mid-1990s were a peculiarly open moment for the security conscious and autocratic Egyptian state. President Hosni Mubarak had been elected for a third term; the Islamic insurgency of the early 1990s had been brutally crushed; Cairo was the scene for the International Conference on Population and Development (ICPD), and the regime was proud of its international status in the revived Middle East peace process. These events gave the government self-assurance to allow a limited internal debate on civil society. The film's producers may have taken advantage of this particular political opening to suggest a more democratic society, as the protagonist argues in the final scenes of the film.
4. The question of impotency is raised here within a heterosexual economy of desire. Same sex relations and homoeroticism is not openly discussed in popular discourses on Arab masculinity (See Ghoussoub 2000; Massad 2002; Murray and Roscoe 1997).
5. My argument about Egyptian society is similar to Judith Farquhar's description of impotency and the changing economy in contemporary China. Farquhar partly shows how in a competitive capitalist market those men who profitably served in Maoist China now find themselves on the margins of the social change.
6. Discussing the hegemonic and subaltern masculinities in the Middle East, Deniz Kandiyoti places the production of masculine identities in generational and institutional terms and shows how masculinities are produced as men move through their respective life cycles. Similarly, Nancy Lindisfarne argues that if hegemonic constructions of masculinity are linked to sexual performance, then the humiliation of impotency and

the failure to deflower brides may also construct subordinate forms. I would add that, as dominant notions of masculinity are unsteady concepts that are created in gender relational terms, they, at least in the Egyptian case, are also intrinsically linked to social and economic circumstances of people's lives (Kandiyoti 1994).

7. I conducted fieldwork during 1992–94 and on revisits to Egypt later in the decade. My fieldwork was in family planning clinics, in offices of international agencies, and in a delta village in the Governorate of Sharquiya in Egypt. I also worked in a poor urban neighborhood of Behteem in the northern suburbs of Cairo.

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8. The Law 203 was enacted in 1991 to restructure and privatize 314 public sector companies, almost 70 percent of Egypt's industrial sector (US Embassy in Cairo 1993).

9. In the last decade or so, the Egyptian state has cooperated with international donor agencies on an ambitious population control program. Emphasizing contrasts between tradition and modernity, the program maintains that rapid population growth is a prime obstacle to realizing the development goals set by the Egyptian state. Accordingly, a high population growth rate (2.6 percent) in the late 1980s was deemed responsible for the economic and social crisis faced by the country. State proclamations and the media primarily held the poor, who have more children, responsible not only for the plight in their personal lives, but also for the country's general economic crisis. An obvious solution to this predicament was to reduce population to levels that would permit the country to continue on its path of development (Ali 2002).

10. For a comprehensive analysis of the family planning program in Egypt, see Ali (2002); Bledsoe (1998); Horn (1994); Kertzer and Fricke (1997); and Reidman (1993).

11. In the late 1970s and the early 1980s, USAID exerted considerable pressure on the Egyptian government to change its focus toward a more directed fertility control program. Bilateral US Assistance to Egypt's population program through the USAID commenced in 1977 and far exceeded any other source of international funding. The timing of the funding was linked to the US administration's peace initiative under President Jimmy Carter and the signing of the peace accord between Egypt and Israel. USAID allocated $87 million in funds between 1977 and 1983 to the state run program, with a promise of an additional $20 million in 1985 (World Bank 1984). An additional $102 million was allocated to the population sector for the years 1983–1988 (to a total of $117 million by 1992). Also see Morsy (1986). In the last 30 years the total amount of USAID funding for Health and Population sector has been $872 million. The estimates were that in 2006 $25 million were given for Family Planning and Health. See "US Aid

to Egypt Totals \$28 Billion in Three Decades", Available online at http://www.usaid.gov/our_work/features/egypt/. Accessed on March 8, 2007.

12. These included the Cairo Family Planning Association, Coptic Evangelical Organization for Social Services, the Association for the Development and Enhancement of Women, and Appropriate Communications Techniques.

13. This use of the concept of civil society is based on the classical Hegelian understanding that separates social life into public and private spheres, where the private family stands in contrast to the public civil society and the state. In terms of intervention into the private sphere, civil society may play a role in furthering developmentalist policies, whether generated by the state or the international community.

14. Non-governmental organizations that use explicitly structural developmental or other approaches to population reduction have not received much external funding. Until the early 1980s, family planning delivery services remained part of a development process that included better living standards, expanded education opportunities, improvement in the status of women, mechanization of agriculture, industrialization in rural areas, lower infant mortality, improved social security coverage, and better informational and communication facilities (Ibrahim 1995).

15. US based consultants, such as Family Health International, Futures Group, Pathfinder, Johns Hopkins University Population Communication Services, and John Snow Inc, supervised these NGOs. USAID-funded NGOs follow the rhetoric of fertility control embedded in policies of expanded contraceptive choice and behavior change. These NGOs aided the expanded policy of service delivery that was projected to be almost 50 percent of the USAID's population budget by 1993. They were also major players in the dissemination of family planning information, in training of counseling techniques to physicians, and in holding workshops and outreach programs to educate women and men on the benefits of contraceptive use. See Gillespie et al. (1989); USAID (1989).

16. Although these subsidies are being rapidly dismantled, middle-class, university-educated NGO employees still berate the poor for relying too much on government handouts.

17. These arguments are comparable to views on welfare reform that have been prevalent in the last decade in the United States, and are clearly influenced by the emphasis placed by international donor agencies on the removal of social subsidies and its link to fertility control.

18. Surveys conducted in developing countries over the last decade to study men's beliefs and practices related to family planning have helped in comprehending men's behavior in fertility regulation and in identifying trends for future family planning policy initiatives (Jejeebhoy and Kulkarni 1989; Khalifa 1988; Mbizvo and Adamchak 1991; Mustafa 1982; Sayed et al. 1992).

19. This shift is related to changes within the discipline of demography that, for example, now emphasizes the micro-practices of individuals as prime determinants of fertility change. Embedded in this new approach, demographic research works with a concept of culture that links a behavioral change model to the acceptability of modern birth control (See Caldwell et al. 1987; Handwerker 1986). This argument again consists of a narrowly construed formulation of culture as communication within a household

with minimal reference to the social, political, and economic forces of the larger society (Greenhalgh 1995: 7). It also encompasses the idea that people in traditional cultures are more fatalistic about their fertility outcomes and are willing to leave reproduction to the will of God (Schneider and Schneider 1995). This understanding of culture effectively places households/families and their behavior patterns on a traditional to modern continuum.

20. Ranajit Guha, in an article on the relationship of the Indian national movement with the Indian masses borrows the Gramscian concept of hegemony to show the processes through which consensus was built by the nationalist elite leadership. He argues that these leaders needed to harness the intuition and enthusiasm of the people so that order could evolve out of chaos. The subalterns' popular initiatives, autonomy of function, the immediacy in their politics and the spontaneity of their actions were to be disciplined by the bourgeois national elite for it to control and hegemonize the national movement. An undisciplined and autonomous subaltern collectivity was to be made into a disciplined controlled national movement that would respond to the desires of the leadership. It is within a similar framework, I suggest that social-actors such as Imam (the film's protagonist)/NGOs (as shown in the previous section) and even modern national governments seek to change the independent and autonomous practices of the lower classes. In the film, through Imam's persuasion, the men (the procession was all male) eventually found their voice and participated in an organized and orderly demonstration to present their grievances to their elected representatives. This was in contrast to the chaos and disorder (the Islamist violence, high crime rates) that the society could ultimately face (as suggested by the physician) if the elite did not seriously attend to the central cause of the affliction—liberal democratic reform. So, Imam's character can be read as a part of those elements in society that pedagogically work toward constructing a responsible citizenry in an attempt to create self-disciplined subjects that respond to their social problems through "proper" political channels rather than through disruptive, violent, and chaotic actions.

21. Michel Foucault argues that the father is not the representative of the sovereign or the state, and the latter are not projections of the father either. Yet the reconstitution of the father's role within the family is necessary to accomplish the transformative requirements of the modern state, whether for the control of population or the medicalization of sex (Foucault 1980).

22. As mentioned, Adil Imam, the protagonist in the film, is a populist character that confronts government ministers and senior bureaucrats and seeks to find the cause and the remedy for this social affliction. His impotency gets cured when he and his wife travel to the desert outside the city and are able to make love. The remedy for impotence found in the desert away from the over-populated urban center hints at the possibility of an ecological argument; a back-to-nature kind of solution that invokes simpler times with less social worries. This theme is not well developed in the film but it has echoes the preoccupation of some Egyptian planners who responded to population growth by proposing new communities to be built in the desert areas not far from Cairo. These self-sufficient towns were meant to provide employment and housing, decreasing the

spatial and social pressures on Cairo. The Ministry of Housing and New Communities issued legislation in 1979 to work toward a master plan for new cities connected to the regional development of cities like Cairo, Port Said, and Ismailia. These satellite cities were estimated to have one-half to one million inhabitants. Some of these schemes have been finished while others are still being developed to encourage people to leave the Nile valley and construct desert communities. The Aswan Dam in the south of the country and the Eastern and Western deserts are propagated as areas where people could earn a living through agriculture, fishing, small industries, or craft production. These schemes notwithstanding, owning a house in Cairo still remains difficult for most low-income households. With credit and house financing on easy installments hard to acquire and with the rising cost of land and construction, renting remains the main solution for most families' housing needs. Families that already have apartments with frozen rents fare better in this market. Young couples that try to get into the rental market now pay more than 25 percent of their salaries, the common standard in a free market economy, to acquire a rental dwelling. This skewed accessibility to shelter has forced most poor families to pool their resources and create what are commonly known as informal housing.

The growth of these housing areas has progressively expanded the city's boundaries. Cairo has spread outward by incorporating agricultural land and the surrounding desert. In densely populated areas, buildings are increased in size by adding additional floors to the already existing residential or commercial structures. Area surveys indicate that the inner city of Cairo is losing population due to changes in land use. The widening of existing roads, the reorganizing of sewerage facilities, the removal of encroachment, and the collapse of old buildings have evacuated people from the more crowded neighborhoods of the city. In contrast the outlying northern, southern and western edges of the city have a very high growth rate and communities have doubled or tripled in size in the last 20 years.

23. Challenging prevalent stereotypes of Arab/Egyptian men, Marcia Inhorn shows the multiple ways in which "conjugal connectivity" happens among urban poor families in Egypt; families in which men and women coexist in an atmosphere of mutual respect, feeling and commitment (Inhorn 1996).

24. Mai Ghoussoub (2000) reminds us, in her reading of historic sex manuals in Arabic, that popular description emphasizes women's overpowering sexuality.

25. This construction of disorder of women is historically present in Western political and social thought as well. In my interviews, this construct was an overarching argument on the need to physically restrain women and also the reason to circumcise them, as circumcision was thought to cool women down sexually. However, in private talks with my male informants, none of them believed that their wives would leave them, as they were very much in love with each other, although most admitted that their sexual lives were affected by their poverty.

26. After the fall of the Berlin Wall in 1989 and the collapse of communism, Yugoslavia began to break up into its six constituent republics in the 1990s, of which Bosnia-Herzegovina was one. Bosnia and Herzegovina became an independent state in March 1992. There followed three years of fighting between Serbs and others, in which

between 100,000 and 250,000 people were killed and more than 2 million displaced. International outrage at Serb war crimes and atrocities (notably the genocidal killing of 8,000 Bosniak men in Srebrenica in July 1995) eventually turned the tide of war. This is important, but my informants did not have such a sophisticated analysis. The common perception was that Muslims were being persecuted and that was leading to a certain politics of solidarity. See also Campbell (2001).

"Ethnic cleansing" was the term the world adopted in the early 1990s for a process in Bosnia through which non-Serbian people—Muslims or Croats—were forced to flee from land which had been deemed to be Serb by Serbian authorities—and killed if they did not. Yet before the war, Bosnia was not Serb or Muslim or Croat but multicultural. Various international schemes to end the violence ended up encouraging violence because they relied on neat conceptual divisions among "ethnic identities" which did not correspond to lived reality. They assumed that antagonists in "ethnic conflicts" are fixed, rigidly-defined groups who supposedly share cultural or racial characteristics and must always be separated to ensure peace. Such apartheid politics ignores the contingent and constructed nature of "ethnic identity" and attempts to remove questions of identify and difference from the realm of politics. Again, the contingency of ethnic identity is important to discuss, but for people who were not historically located in the debates, the issue was more black and white. I am not agreeing with their position, just reporting and showing what were the motivations for such discussions.

27. This argument is akin to the one that Julie Peteet makes while describing how physical violence perpetuated during the first *Intifada* by the Israeli security forces on the bodies of Palestinian young men became their rites of passages into adulthood. She argues that Israeli security services shifted their techniques of torture and violence once they realized that acts of bodily violence take on the meaning of empowerment and future political agency for the tortured men. Rape and other kinds of sexual violence started becoming more common to deprive men of their masculinity and manhood.

28. See Elyachar (2002) for further elaboration of this theme.

29. A role bravely played by some of these NGOs. The Egyptian Organization of Human Rights, among other groups, has been repeatedly harassed and intimidated by the Egyptian state security services.

30. For those Egyptian NGOs that are more radical and politically active, it is, however, extremely difficult to survive as a legal entity. Under Egyptian law, all not-for-profit groups need to be registered with the Ministry of Social affairs that retains the right to close down any organization that it deems subversive. A new Law 156 was imposed in 1999, which in addition to earlier restrictions on legal and administrative structures, requires NGOs to seek approval from the Ministry of Social Affairs before accepting foreign donations/grants, prohibits NGOs from participating in political and unionist activities, and closes the legal loop hole used by some NGOs to register as not-for-profit "civil companies" to avoid the provisions of the earlier Law. See El-Gawhary (2000).

31. Like the Human Rights NGOs, the state security apparatus also periodically harasses those that speak about democratic reform. For example, after the International

     Conference on Population and Development (ICPD) in Cairo (1994), the state apparatus put greater legal restrictions on the functioning of secular women's groups and NGOs. In recent years the Egyptian state has further strictly monitored foreign funding of NGOs; in the process it has sought to stifle the voices of those groups that criticize it.

32.   A common phrase used in colloquial Arabic that links the image of donkeys to yes-men.

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10

What has Happened in
Africa since Cairo?*

MEREDETH TURSHEN

What has happened in Africa in the decade since the United Nations convened the International Conference on Population and Development in Cairo? The data reveal the stark answers to the question.[1]

Since 1986 the poorest African countries grew poorer while the richest nations of the North got (much) richer. Table 10.1 shows GNP per person for the 10 poorest countries ranked in ascending order according to World Bank data for 2003 in comparison with GNP for 1986; remarkably, incomes fell or were stagnant in eight of the 10 cases. For the 10 richest countries, ranked in descending order according to World Bank data for 2003, the increase in GNP per person since 1986 is dramatic; in each case incomes have more than doubled.

In the decade since Cairo, life expectancy fell in Africa. Table 10.2 shows life expectancy at birth in selected sub-Saharan African countries ranked in descending order according to UNDP (United Nations Development Programme) data for 1992. Between 1992 and 2003, life expectancy at birth rose in the high income countries and in 14 (mainly west) African countries. Life expectancy fell in 25 of the 40 countries for which data are available. In 10 countries it fell precipitously, defined as a drop of more than 10 years in the 11-year period.

Since 1990 maternal mortality rates have risen or stayed the same in 16 of 40 African countries. Table 10.3 compares the data available for 1990 with the most recent data for maternal mortality rates per 100,000

Table 10.1 The poorest growing poorer, the richest getting (much) richer, GNP per person (US$)

Poorest countries	1986	2003	Richest countries	1986	2003
Ethiopia	120	90	Norway	15,400	43,350
Burundi	240	100	Switzerland	17,680	39,880
Congo (DRC)	160	100	USA	17,480	37,610
Sierra Leone	310	150	Japan	12,840	34,510
Malawi	160	170	Denmark	12,600	33,750
Niger	260	200	Sweden	13,160	28,840
Mozambique	210	210	UK	8,870	28,350
Rwanda	290	220	Finland	12,160	27,010
Uganda	230	240	Austria	9,990	26,720
Central African Republic	290	260	The Netherlands	10,020	26,310

Source World Bank (2005b).

Table 10.2 Life expectancy at birth in selected sub-Saharan African countries

	1992	2003		1992	2003
Botswana	64.9	36.3	Nigeria	50.4	43.4
South Africa	62.9	48.4	Burundi	50.2	43.6
Lesotho	60.5	36.3	Central African Republic	49.4	39.3
Namibia	58.8	48.3	Senegal	49.3	55.7
Swaziland	57.5	32.5	Zambia	48.9	37.5
Madagascar	56.5	55.4	Benin	47.6	54.0
Cameroon	56.0	45.8	Chad	47.5	43.6
Ghana	56.0	56.8	Ethiopia	47.5	47.6
Kenya	55.7	47.2	Burkina Faso	47.4	47.5
Liberia	55.4	42.5	Rwanda	47.3	43.9
Togo	55.0	54.3	Somalia	47.0	44.0
Zimbabwe	53.7	36.9	Angola	46.5	40.8
Gabon	53.5	54.5	Niger	46.5	44.4
Sudan	53.0	56.4	Mozambique	46.4	41.9
Tanzania	52.1	46.0	Mali	46.0	47.9
Congo (Kinshasa)	52.0	43.1	Malawi	45.6	38.7
Mauritania	51.5	52.7	Gambia	45.0	55.7
Congo (Brazzaville)	51.3	52.0	Uganda	44.9	47.3
Côte d'Ivoire	51.0	45.9	Guinea	44.5	53.7
Sub-Saharan Africa	50.8	46.1	Sierra Leone	39.0	40.8
High income countries	76.1	78.8			

Source UNDP (1995, 2005).

Table 10.3 Maternal mortality rates per 100,000 live births for selected sub-Saharan African countries

	1990	*Most recent*
Angola	1,500	1,700
Benin	990	850
Botswana	250	100
Burkina Faso	930	1,000
Burundi	1,300	1,000
Cameroon	550	730
Central African Republic	700	1,100
Chad	1,500	1,100
Congo (Brazzaville)	890	510
Congo (Kinshasa)	870	990
Côte d'Ivoire	810	690
Eritrea	1,400	630
Ethiopia	1,400	850
Gabon	500	420
Gambia	1,100	540
Ghana	740	540
Guinea	1,600	740
Guinea-Bissau	910	1,100
Kenya	650	1,000
Lesotho	610	550
Liberia	560	760
Madagascar	490	550
Malawi	560	1,800
Mali	1,200	1,200
Mauritania	930	1,000
Mauritius	120	24
Mozambique	1,500	1,000
Namibia	370	300
Niger	1,200	1,600
Nigeria	1,000	800
Rwanda	1,300	1,400
Senegal	1,200	690
Sierra Leone	1,800	2,000
South Africa	230	230
Swaziland	560	370
Tanzania	770	1,500
Togo	640	570
Uganda	1,200	880
Zambia	940	750
Zimbabwe	570	1,100

Source UNFPA (2005).

live births in selected sub-Saharan African countries. Table 10.4 shows maternal mortality ratios in the year 2000 for the same 10 countries shown in Table 10.1, ranked in the same order (ascending for the poorest countries, descending for the richest countries). Remarkably, the lifetime *risk* of dying in childbirth or from causes related to pregnancy in the poorest countries approximated the maternal mortality rate in the richest countries.

Table 10.4 Maternal mortality ratios, 2000 (adjusted rates), and lifetime risk of maternal death

Poorest countries	Rate	Risk 1 in:	Richest countries	Rate	Risk 1 in:
Burundi	1,000	12	Norway	16	2,900
Congo (DRC)	990	13	Switzerland	7	7,900
Sierra Leone	2,000	6	USA	17	2,500
Malawi	1,800	7	Japan	10	6,000
Niger	1,600	7	Denmark	5	9,800
Mozambique	1,000	14	Sweden	2	29,800
Rwanda	1,400	10	UK	13	3,800
Uganda	880	13	Finland	6	8,200
Central African Republic	1,100	15	Austria	4	16,000
			The Netherlands	16	3,500

Source UNICEF (2005).

Since Cairo skilled personnel attended fewer births in 12 of 31 countries for which comparative data are available. Table 10.5 shows the percentage of deliveries with a skilled attendant in 1990 compared to the most recent year for which data are available.

Since Cairo, the rates of preventable and treatable communicable diseases have risen—not only AIDS but malaria and tuberculosis as well. Table 10.6 compares (as far as possible) data for 1993 and 2003 for AIDS, malaria, and tuberculosis. For malaria, case rates went up in slightly more countries than they went down (19/18); in one (South Africa) the rate remained the same—0.3 per 1,000. Malaria rates went up by more than 30 cases per 1,000 in slightly more countries than rates dropped by that number (8/6). Note the lack of data for AIDS case rates for 2003 (only HIV prevalence rates are available). What can be the meaning of HIV prevalence rates in Africa where WHO bases the definition of a case of AIDS on four symptoms (weight loss, cough, fever, and diarrhea), not on an HIV test?[2] And why does WHO have almost no data for tuberculosis

Table 10.5   Deliveries with skilled attendant (percent) in selected sub-Saharan African countries

	1990	*Most recent*
Angola	16	45
Benin	51	66
Botswana	78	94
Burkina Faso	33	38
Burundi	26	25
Cameroon	25	60
Central African Republic	66	44
Chad	21	16
Congo (Brazzaville)	na	na
Congo (Kinshasa)	na	61
Côte d'Ivoire	50	63
Eritrea	na	28
Ethiopia	10	6
Gabon	na	86
Gambia	65	55
Ghana	42	47
Guinea	76	35
Guinea-Bissau	39	35
Kenya	28	42
Lesotho	40	60
Liberia	na	51
Madagascar	71	46
Malawi	41	61
Mali	14	41
Mauritania	40	57
Mauritius	91	99
Mozambique	29	45
Namibia	71	76
Niger	21	16
Nigeria	45	35
Rwanda	28	31
Senegal	40	51
Sierra Leone	na	42
South Africa	na	84
Swaziland	55	70
Tanzania	60	36
Togo	56	49
Uganda	na	39
Zambia	43	43
Zimbabwe	65	73

Source   UNFPA (2005).

Table 10.6 AIDS, malaria, and tuberculosis in selected sub-Saharan African countries

	AIDS cases/ 100,000	HIV prevalence 15–49 (%)	Malaria cases/ 1,000		TB cases/ 100,000	
	1993	2003	1993	Most recent	1990	2003
Angola	1.2	3.9	70.6	106.9	–	256
Benin	5.3	1.9	78.5	122.0	–	141
Botswana	68.5	37.3	37.6	12.6	–	342
Burkina Faso	–	4.2	51.6	114.9	–	303
Burundi	13.4	6.0	140.4	274.0	–	519
Cameroon	7.1	6.9	37.7	29.0	194	221
CAR	13.5***	13.5	25.8	24.7	–	493
Chad	16.5***	4.8	37.0	47.7	–	439
Congo	52.0	4.9	5.6	5.3	–	489
Congo, DR	1.5	4.2	4.4*	83.1	333	537
Côte d'Ivoire	28.3	7.0	30.8	24.9	196	618
Eritrea	–	2.7	25.3**	17.4	–	431
Ethiopia	10.1	4.2	5.7	6.0	–	507
Gabon	6.2	8.1	67.8	66.8	–	242
Gambia	1.2	1.2	278.3***	100.5	–	337
Ghana	12.2	3.1	102.1	169.8	222	369
Guinea	4.4	3.2	85.6***	109.5	–	394
Guinea-Bissau	8.7	–	142.0	134.6	–	300
Kenya	10.3	6.7	228.9***	3.9	140	821
Lesotho	15.4	28.9	–	–	–	390

Madagascar	–	1.7	14.2**	121.5	310	325
Malawi	52.8	14.2	475.5	240.4	–	469
Mali	6.6	1.9	30.2	62.2	–	582
Mauritania	0.5	0.6	20.1	59.6	–	664
Mozambique	1.0	12.2	0.8*	269.7	–	557
Namibia	71.8	21.3	245.2	223.4	–	477
Niger	1.4	1.2	86.0	59.1	–	272
Nigeria	0.3	5.4	10.4	21.0	222	518
Rwanda	15.2	5.1	131.7	102.1	–	628
Senegal	4.4	0.8	55.3***	119.3	166	429
Sierra Leone	0.3	–	2.4	95.4	–	794
South Africa	4.2	21.5	0.3	0.3	250	341
Sudan	0.7	2.3	368.9	91.8	–	355
Swaziland	18.9	38.8	14.6**	34.0	–	683
Tanzania	–	8.8	303.2	289.7	140	476
Togo	35.1	4.1	152.4	92.1	244	673
Uganda	45.2	4.1	77.0	477.9	–	621
Zambia	239.3	16.5	394.5	190.2	345	508
Zimbabwe	86.0	23.6	77.9	97.6	207	500

Source World Bank (1995, 2005b); UNDP (1995, 2005); WHO (2005).

Notes * denotes 1996.

    ** denotes 1995.

    *** denotes 1994.

cases in 1990 (the WHO TB program dates back to the 1950s)? In some
countries poor statistical services and years of conflict account for the lack
of data, but so do World Bank retrenchment programs, which have cut
government health budgets, health personnel, and public education, all of
which affect the availability of statisticians.

In the decade since Cairo, public expenditure on health has stagnated in
24 of 25 countries for which the data are available; the health budget has
risen only on the island of Mauritius. One cannot lay the blame on military
budgets because the majority of countries have reduced military spending
(the budget went down in 11, remained the same in three, and went up
in two countries). Table 10.7 compares public expenditure on health and
military expenditure as percentage of GDP for the years 1990 and 2002.

Table 10.7 Public expenditure on health and military expenditure as
a percentage of GDP for selected sub-Saharan African
countries

	Health expenditure		Military expenditure	
	1990	*2002*	*1990*	*2002*
Botswana	3.7	3.7	4.1	4.1
Burkina Faso	2.0	2.0	3.0	1.3
Cameroon	1.2	1.2	1.5	1.5
Central African Rep.	1.6	1.6	–	1.3
Congo (Brazzaville)	1.5	1.5	–	1.4
Côte d'Ivoire	1.4	1.4	1.3	1.5
Ethiopia	2.6	2.6	8.5	4.3
Gambia	3.3	3.3	1.1	0.5
Ghana	2.3	2.3	0.7	0.4
Kenya	2.2	2.2	2.9	1.7
Lesotho	5.3	5.3	4.5	2.6
Madagascar	1.2	1.2	1.2	–
Malawi	4.0	4.0	1.3	–
Mali	2.3	2.3	2.1	1.9
Mauritius	3.8	4.7	2.2	2.2
Namibia	4.7	4.7	–	2.8
Niger	2.0	2.0	–	–
Senegal	2.3	2.3	2.0	1.5
Sierra Leone	1.7	1.7	1.4	1.7
Tanzania	2.7	2.7	–	2.1
Togo	5.1	5.1	3.1	1.6
Uganda	2.1	2.1	3.0	2.3
Zambia	3.1	3.1	3.7	–
Zimbabwe	4.4	4.4	4.5	2.1

Source UNDP (2005).

Another measure of investment in health is the ratio of physicians and nurses. Table 10.8 shows the number of physicians per 100,000 population, comparing the period 1988–1992 with the most recent data. Also shown is the annual population growth rate for the period 1975–2003 to give a sense of the increasing need for maternal and child health as well as other medical services. Ratios of physicians fell in four countries and remained the same in another four; they rose in 16 countries, but not at the rate of population growth. The issue of brain drain is discussed in the following pages.

Table 10.8 Physicians per 100,000 population 1988–1992 and most recent year, and annual population growth rate (percent) 1975–2003, for selected African countries

	1988–1992	*Most recent year*		*Annual population growth rate % 1975–2003*
Angola	7	8	1997	2.8
Botswana	–	40	2004	2.5
Burkina Faso	3	6	2004	2.6
Cameroon	8	19	2004	2.6
Central African Republic	4	8	2004	2.3
Côte d'Ivoire	6	12	2004	3.5
Ethiopia	3	3	2003	2.8
Gambia	–	11	2003	–
Ghana	4	15	2004	2.6
Kenya	14	30	2004	3.2
Lesotho	–	5	2003	1.6
Malawi	2	2	2004	3.1
Mali	5	8	2004	2.6
Mauritius	–	106	2004	1.1
Mozambique	2	3	2004	2.1
Niger	3	3	2004	3.2
Nigeria	15	28	2003	2.7
Rwanda	2	5	2004	2.5
Senegal	5	6	2004	2.7
Sierra Leone	7	3	2004	2.0
Somalia	7	4	1997	–
South Africa	61	77	2004	2.1
Sudan	9	22	2004	2.6
Tanzania	3	2	2002	3.0
Togo	8	4	2004	3.1
Uganda	4	8	2004	3.3
Zambia	9	12	2004	2.8
Zimbabwe	16	16	2004	2.6

Source World Bank (1993); WHO (2006); UNDP (2005).

Family planning is the one service that grew in the decade since Cairo; the higher percentage of married women of childbearing age using contraceptives is a measurement of increased access to family planning services. Table 10.9 shows that in 16 countries women increased their use of contraception, in one country the percentage stayed the same, and in four countries use of contraceptives went down.

Table 10.9 Married women of childbearing age using contraception (percent) in selected sub-Saharan African countries

	1988–1993	*Most recent*
Botswana	5.4	4.9
Burkina Faso	5.8	11.9
Cameroon	5.1	4.8
CAR	5.1	27.9
Côte d'Ivoire	3.9	15.0
Ethiopia	4.0	8.1
Gambia	7.4	9.0
Ghana	7.0	7.0
Kenya	7.8	5.4
Lesotho	6.2	11.5
Malawi	5.5	30.6
Mali	3.1	8.1
Mauritius	7.5	9.4
Niger	4.1	14.0
Senegal	4.7	12.9
Sierra Leone	9.1	4.3
Tanzania	6.0	25.4
Togo	6.1	25.7
Uganda	5.1	22.8
Zambia	6.1	34.2
Zimbabwe	5.4	53.5

Source World Bank (1995); UNFPA (2005).

SO WHAT DID CAIRO ACCOMPLISH FOR AFRICAN WOMEN?

Using the data given above to measure achievement of the key goals embodied in the ICPD Programme of Action, we may conclude that governments have achieved only one goal: providing skilled attendants to assist 40 percent of all births where the maternal mortality rate is very high (interpreted here as over 1,000 per 100,000 live births). The median in

Table 10.5 is 45 percent, but this figure is misleading as the range is from 6 to 99 percent. Table 10.4 shows maternal mortality for the poorest African countries, all of which have very high rates. Here an average 40 percent of births are assisted by skilled attendants. It is noteworthy that in 1990 governments provided skilled attendants to assist 32.5 percent of all births where the maternal mortality rate was over 1,000 per 100,000 live births. So let's hold the applause, especially as governments are unlikely to meet the goal of reducing maternal mortality by 100 percent by 2015.

Governments have not met the 2005 goal of halving the 1990 illiteracy rate for women and girls, which was 62 percent. In the period 2000–2004 the adult female illiteracy rate was 48 percent.

Governments have not met the goal of offering the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted infections, and methods to prevent infection, in 60 percent of primary health care and family planning facilities by 2005. Also absent is an ability to track the services offered in primary health care and family planning facilities, let alone evaluate the quality, safety, and effectiveness of the services, all proxy measurements of maternal mortality, and use of contraception. On these measures, as shown by the data in Tables 10.3, 10.4, 10.5, and 10.9, African governments are not reaching these goals.

Governments have not met the 2005 goal of reducing by half the gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families. Family planning services have yet to meet the needs of about one-fourth of individuals expressing a desire to space or limit their families; this figure has fallen from about one-third of individuals in 1990. In other words, governments have made some progress in meeting this target but have not yet achieved it.

Judging by the rising rates of HIV infection, governments have probably not met the 2005 goal of reducing vulnerability to AIDS by giving access to preventive contraceptive methods such as female and male condoms, voluntary testing, counseling, and follow-up to the maximum number of young men and women, aged 15–24. We say probably not met because the UNAIDS data are highly unreliable as they combine infection rates with case rates (not done for any other disease) and use estimates without revealing the assumptions that go into the mathematical models.

THE REALITIES OF AFRICAN HEALTH BUDGETS

Before condemning African governments for failing to meet the goals set in the Cairo Programme of Action, let us consider the realities of health budgets. Table 10.10 shows public expenditures on health per capita in US dollars in selected sub-Saharan African countries. Eleven countries spend less than $5 per person per year; another 15 spend less than $10. The WHO Commission on Macroeconomics and Health (WHO 2001) estimated the cost of a set of essential interventions at $34 per person per year, much of which would need to be public spending, or $45 to include some additional hospital services. Public spending on health care is catastrophically low thanks in large part to World Bank-imposed structural adjustment programs, which cut public services and the salaries of public service personnel and commercialized health services. Also at fault is the Bank's disastrous "user fee" policy, which in Zimbabwe has made hospital delivery unaffordable and accounts for some of the rise in maternal mortality in that country (Turshen 1999).

Table 10.10 Public expenditures on health per capita (US$) in selected sub-Saharan African countries, most recent year

Angola	15.96	Liberia	2.67
Benin	8.94	Madagascar	2.86
Botswana	105.45	Malawi	5.71
Burkina Faso	5.12	Mali	6.13
Burundi	.60	Mauritania	10.41
Cameroon	8.09	Mauritius	85.72
Central African Republic	4.51	Mozambique	7.78
Chad	5.82	Namibia	69.45
Congo (Brazzaville)	12.27	Niger	3.50
Congo (Kinshasa)	1.10	Nigeria	4.85
Côte d'Ivoire	9.94	Rwanda	6.20
Eritrea	5.02	Senegal	12.18
Ethiopia	2.28	Sierra Leone	3.52
Gabon	66.56	South Africa	82.87
Gambia	8.14	Swaziland	39.60
Ghana	6.98	Tanzania	7.16
Guinea	3.41	Togo	67.26
Guinea-Bissau	4.29	Uganda	5.11
Kenya	8.53	Zambia	10.69
Lesotho	21.37	Zimbabwe	61.08

Source UNFPA (2005).

Africans spend more on out of pocket on health care than US Americans. WHO (2006) points out that in only three African countries (Lesotho, Namibia, and South Africa) people's out of pocket expenditure is less than one-quarter of their total spending on health; in the United States the figure is 24.3 percent. People in another five countries pay for between one-quarter and one-half of their health care spending out of pocket; in a further four countries they spend between one-half and three-quarters. In seven countries, meanwhile, Africans incur 75 to 89 percent of their expenditure on health from out of their own pockets; in 22 countries, 90 and 100 percent of people's expenditure of health is out of pocket. With 75 percent of Africans living below the $2 per day poverty line, it is unrealistic to expect the vast majority to be able to pay for their health care.

THE REALITIES OF BRAIN DRAIN

So what has happened in the decade since Cairo that might account for so little progress in some areas and such heavy reversals? First, there is the acceleration of brain drain, yet another way in which the North drains resources from Africa.

Brain drain takes several forms: the drift of trained African health personnel from rural to urban areas, from primary to tertiary health facilities, and from the public to the private sector within their countries. In addition, professionals move from their countries to South Africa and from African countries to Europe, Oceania, and North America. African countries not only absorb the costs of social reproduction and medical education but also sustain the loss of their trained personnel. Table 10.11 shows the clustering of professional health staff in central and provincial hospitals in the late 1990s for three southern African countries: Malawi, Zambia, and Zimbabwe.

Table 10.11 Percentage distribution of professional health staff by level of facility (late 1990s)

Country	Central/provincial hospitals	Rural health centers	Other (central HQ, etc.)
Malawi	54	16	30
Zambia	41	19	40
Zimbabwe	51	5	44

Source Padarath et al. (2003).

According to a recent World Bank study (2005a), one-third to two-thirds of the college-educated citizens of many African countries live abroad in an OECD country. Table 10.12 shows the emigration of skilled Africans in 2000. It is not just the loss of skilled personnel, it is also the vicious downward cycle of underdevelopment fueled by brain drain because it is the "feisty people with the spark and ability to resist corruption and incompetent government" who leave, resulting in a loss of institution builders—hospital managers, university department heads, and political reformers (Kapur and McHale 2005). Note the smaller the country, the more acutely is brain drain felt.

A recently published study by Fitzhugh Mullan (2005) gives "emigration factors", which are measures of physicians from Africa practicing in one of four OECD countries (Australia, Canada, England, and the United States). As shown in Table 10.13 the factors range from 30 for Ghana to 11.1 for Sudan.

In 1999, 40 of Ghana's 43 final year medical students planned to leave immediately after graduation while 70 percent of its 1995 graduates had already migrated by 1999 (Padarath et al. 2003). Another study showed that 40 percent of a cohort of Nigerian medical graduates were living abroad

Table 10.12   Skilled emigration from African countries, 2000

Country	Emigration rate %
Cape Verde	67.5
Gambia	63.3
Mauritius	56.2
Seychelles	55.9
Sierra Leone	52.5
Ghana	46.9
Mozambique	45.1
Liberia	45.0
Kenya	38.4
Uganda	35.6
Angola	33.0
Somalia	32.7
Rwanda	26.0
Malawi	18.7
Senegal	17.7
Cameroon	17.2
Zambia	16.8

Source   World Bank (2005a).

Table 10.13   Emigration factors for physicians from African countries

Source country	Emigration factor
Ghana	30.0
South Africa	18.5
Ethiopia	15.4
Uganda	14.2
Nigeria	11.6
Sudan	11.1

Source   Mullan (2005).

10 years after qualifying (*The Lancet* 2005). The hemorrhaging of clinical and professional leaders crippling already fragile health care systems is nothing less than a fatal flow because the poor are left vulnerable to devastating diseases and avoidable death. Working conditions deteriorate as personnel migrate and in turn the deteriorating conditions become an incentive for others to migrate. "The exodus also constitutes a silent theft from the poorest countries through the loss of public subsidies for medical education, estimated at $500 million annually for all emigrating skilled workers from Africa" (Chen and Boufford 2005).

PHANTOM AID

The second important difference in the decade since Cairo is the phenomenon many are calling "phantom aid", the unfulfilled promises of assistance, whether for the ICPD Programme of Action or the Millennium Development Goals. The South Africa-based British charity ActionAid International (2005, 2006) found that 61 percent of aid from the United Kingdom was "phantom" rather than "real", rising to almost 90 percent in the case of France and the United States. The bulk of the money is wasted, misdirected, or recycled within rich countries. Agencies fail to target the poorest countries, spend too much on overpriced technical assistance from international consultants, and tie aid to purchases from donor countries' own firms. Their planning, implementation, monitoring, and reporting requirements are cumbersome and poorly coordinated, administrative costs are excessive, and disbursements are late and partial. Compared with a UN target of 0.7 percent of GNP, rich countries are ostensibly spending

0.25 percent of their national income on aid each year. Subtracting "phantom aid", the real value of foreign assistance is 0.1 percent (Elliott 2005).

Typical is the Millennium Challenge Corporation, the aid initiative of former President George W. Bush, which promised to provide $5 billion annually in foreign aid. Instead of hiring aid experts, the Bush administration staffed the Corporation with conservative ideologues, eschewed cooperation with the venerable USAID, and operated on its own rather than partnering with other countries. Instead of funding projects like building schools and hospitals, providing electricity, and delivering clean water to rural villages, which directly aid the poor, the Corporation favors projects closely linked to the private sector, especially those that benefit commercial deals and investors. While the Corporation steers aid to business ($86 million to mobilize investment and build the infrastructure needed to move goods to market in Cape Verde, nearly all of the $110 million in aid to the impoverished country), the president has slashed funding for children's health in the Democratic Republic of the Congo, Ethiopia, Liberia, and Uganda. The president announced his initiative in 2002; four years later the Corporation has signed contract with only six countries and offered only $1.2 billion in assistance (Kurlantzick 2006).

DfID, the UK Department for International Development, a counterpart to USAID, also ties aid to foreign policy and links it with commercial interests and the push for privatization; developing countries do not have the option of keeping essential services in the public sector but must privatize or risk having their aid cut off. From 1997 to 2003, DfID gave five times as much humanitarian aid to European emergencies as it did for emergencies in Africa (Shifrin 2004). Former Prime Minister Tony Blair promised to double aid and "make poverty history" at the G-8 summit in Gleneagles, Scotland, in 2005. Evaluations of the summit noted little progress beyond the pledges on debt relief implemented over the past year (Minter 2006).

POVERTY IN AFRICA

The third important difference in the decade since Cairo is the dramatic increase in poverty, as shown in Table 10.1 and implied in other data. To answer the question, why can't Africans afford public health systems,

one must consider that sub-Saharan Africa is regularly dispossessed of its wealth. To understand this statement, calculate the value of South–North resource flows associated with exploitative debt and finance, phantom aid, capital flight, unfair trade, distorted investment, ecological exploitation, and the brain drain. Take, for example, capital flows and capital flight: remittances from the African Diaspora now fund development and even some capital accumulation, but capital flight is far greater—more than $10 billion per year since the early 1970s from Nigeria, Côte d'Ivoire, Congo (Kinshasa), Angola, and Zambia (Bond 2005). This figure is probably an underestimate. Nigeria's annual capital flight in the mid-1990s was $4 billion, not including the Gulf War oil windfall of $12 billion never accounted for. Worldwide possibly one trillion dollars a year—or half of all global wealth flows—has gone into overseas bank accounts, lost to falsified trade pricing (under/over invoicing), and criminal money laundering. From 1982 to 1991 sub-Saharan Africa lost about $22 billion to Euro-American financial systems (Ifeka 2003/04). Capital held overseas is estimated at 39 percent of Africa's GDP. In Nigeria, the figure is 133 percent of GDP (ibid.).

Africa is poor because it is drained of genuine savings through depletion of minerals and forests, through the damage to African countries by trade liberalization, estimated at $272 billion since 1980, and through the loss of public subsidies for medical education, estimated at $500 million annually for all emigrating skilled workers from Africa (see Table 10.14).

Table 10.14   Losses per person from subsoil assets, timber resources, non-timber forest resources, protected areas, cropland, and pastureland, 2000

Gabon	–$2,241
Congo (Brazzaville)	–$727
Nigeria	–$210
Cameroon	–$152
Mauritania	–$147
Cote d'Ivoire	–$100

Source Bond (2005).

Above all, Africa is poor because between 1970 and 2002, the African continent received some $540 billion in loans and paid back some $550 billion in principal and interest. Yet Africa remained with a debt stock of $295 billion (UNCTAD 2004).

CONCLUSION

At the beginning of this chapter, we posed the question, what has happened in Africa since Cairo? The answer is that on too many fronts, especially in the areas of ICPD promises, the countries and people of sub-Saharan Africa have moved backwards or have stagnated and made no progress. Northern leaders will round up the usual suspects for blame: AIDS, war, corruption. As to AIDS, a look at the data in Table 10.6 shows that some of the highest AIDS rates are in the countries of southern Africa subjected to conflicts that were the legacies of the Cold War. In addition to the cold war, one must fault the role of the World Bank in the AIDS epidemic and the responsibility of structural adjustment programs for the spread of AIDS in Africa (Kalipeni et al. 2004). Corruption and conflict are the consequences of states weakened by structural adjustment programs with little ability to police rebel movements or the bureaucracy, let alone multinational corporations. Bond (2005) shows the ways that corruption follows World Bank privatization programs in Africa.

The focus on AIDS in the Millennium Development Goals (which closely monitor the sexual activity of young people) is a focus on contraception (abstinence and condoms), a convenient coincidence with population control targets and the ICPD Programme of Action. It is questionable whether AIDS should hijack health budgets when so many other health problems demand attention. It is questionable whether scarce drug dollars should go to palliative AIDS treatment, when malaria and tuberculosis, preventable and treatable diseases, have higher priority across the continent. It is questionable whether, once again, governments should construct a vertical program to treat one particular condition, distorting basic health services. It is questionable whether the focus of public health should be shifted to the intensive, clinical, hospital-based medicine that AIDS treatment demands when so many Africans are without potable water and basic sanitation, which could prevent far more widespread conditions like the water-borne diseases: cholera, dysentery, and diarrhea. Finally, it is questionable whether we should allow a virus, a convenient and simple target to rationalize medical responses, to deflect attention from long-term social and economic transformation of the conditions that make people vulnerable to the disease (Murphy 2004).

Living in the United States, we witness our leaders waging unprovoked wars in Afghanistan and Iraq, the under-funding of AIDS programs at

home as well as abroad, the untrammeled profits of the pharmaceutical industry, and corruption at the highest levels of corporate and government power. No need to look South for these excuses for the failure to improve people's basic living and working conditions.

NOTES

1. Most UN sources publish data with a three-year time lag; data for 2004 are not yet available. This chapter uses the most recent data available.
2. See Murphy (2004) for a non-polemical review of the skeptic's position on HIV testing.

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11

Reproductive Health, Family Planning, and HIV/AIDS: Dangers of (Dis)Integration in Tanzania and Uganda

LISA ANN RICHEY

INTRODUCTION

For over a decade, the international community has acknowledged that debates over population and development would be better focused toward improving the status of women's reproductive health, instead of focusing on a narrowly-defined agenda of fertility control. This agenda expands the scope of population interventions to embrace a wide array of concerns centered on reducing the morbidity and mortality of poor women and their children. The paradigm shift toward reproductive health has been heralded as a step forward, moving beyond the narrow depictions of a population problem that can be solved by contraception. But the relationship between fertility limitation and improved women's and children's health is complex, and may not always be complementary given the realities of the post-adjustment health care system and the realities of HIV/AIDS. The public health sector, debilitated by both economic crises and their solutions, presents formidable obstacles to successful implementation of a reproductive health agenda.

International and national efforts for combating HIV/AIDS and those that promote reproductive health remain separate in conceptualization

and implementation, while local negotiations around reproductive health issues reflect a similar lack of explicit attention to HIV/AIDS. Yet, this chapter argues that even in reproductive health clinics there is a gap between our knowledge of the HIV/AIDS epidemic and the lack of AIDS talk, and there is also a mismatch between the behavioral and biomedical context of AIDS we know in the aggregate and the socio-economic context of AIDS as a lived experience. Separate and competing vertical programs on AIDS and Maternal and Child Health/Family Planning, common throughout Africa, cannot meet the needs of women in countries like Tanzania and Uganda.

Reproductive health has become a paradox of post-conditionality. Certain aspects of the reproductive health agenda—fertility reduction in Tanzania and HIV/AIDS prevention in Uganda—have been achievable within the constraints of a limited public health care environment; however this success has been circumscribed. Privileged, vertical programs relying on foreign assistance and domestic political support have been able to meet some of the goals of the Cairo agenda, but there has been little spill-over into improving the overall public health sector or into promoting other aspects of the larger agenda. While there is no question that providing contraceptives and HIV/AIDS prevention services are important in these countries, the limited impact of the ambitious reproductive health agenda in both countries has been disappointing.

Tanzania and Uganda have been termed "post-conditionality" regimes (Harrison 2001)—a useful way of thinking about the context of development interventions. In post-conditionality states, implementing structural adjustment measures is no longer a political issue; it is simply taken for granted, and thus, donors use the disbursement of funds to promote further changes rather than to threaten withdrawal if a country does not live up to the conditionalities (ibid.: 659).[1] In this state of "post-conditionality", there is a mutual dependence between donors and the state, as the donors identify good reformers and then are anxious to see further success to justify their past policies and selection of good states for interventions. International donors and lenders in post-conditionality states assume a less visible but perhaps even more powerful role than they held during the formal adjustment period. Hence, it is no longer useful to separate the interests of internal and external forces or state versus donors in the post-conditionality regime—donors are part of the state itself. In some

particularly donor-reliant arenas, like that of population policy, this has been the case for some time.

In Tanzania, population control has been an important part of the bundle of recommendations given under the rubric of structural adjustment. Over-all, the proportion of Tanzanian national public expenditure going to reproductive health declined after 1994, and the bulk of earmarked funds have been for contraceptive procurement (Standing 2002: 13). We know that the total fertility rate has been dropping in Tanzania, as it is in many other parts of the developing world, even if it is not certain how much of the decline can be attributed to contracepting in general, or to the family planning program specifically. Without question, donors have succeeded in funding a national family planning program that has raised awareness, access, and use of contraceptives throughout the country. While there are lessons from the success of the family planning program that may inform other aspects of the reproductive health agenda, the breadth of this agenda and the severity of health crises it intends to address, including HIV/AIDS, call for a rethinking of the relationship between vertical donor-reliant programs and the post-adjustment health context in which they operate.

Uganda has been presented as the first African "success" story in the fight against HIV/AIDS, and boasts one of the most effective women's movements in Africa (Tripp 2000). Given the outspoken leadership on HIV/AIDS, we might expect that official attention would be expanded to include issues of women's reproductive health and rights, making for a strong national program to implement the Cairo framework. Yet, Uganda has experienced no decline in fertility rates, infant mortality rates have risen, and access to reproductive health services is limited. In com-paring the Ugandan policy responses in two important areas, we see strong national leadership on AIDS, but no coherent vision on reproductive health. The Ugandan success in HIV/AIDS policy has been important for its donors, and international assistance is critical to health care provision in Uganda. However, the implementation of reproductive health has been limited, and its non-AIDS related components have been largely unsuccessful.

This chapter analyzes the agenda of reproductive health in Tanzania and Uganda by examining existing demographic and health data, and interviews with informants from the government, donors, and NGOs. It argues that the future of a successful reproductive health policy that

extends beyond family planning and includes HIV/AIDS will be shaped by international agendas and funds, including the increasing demand for AIDS treatment. Treatment demands, like other components of the reproductive health agenda, will require investments in the health care delivery system. Thus, the post-conditionality context must be taken seriously if reproductive health is to become more than a cloak for targeted, vertical interventions in areas of donor interest.

TANZANIA

It has been generally acknowledged that family planning is still receiving the most attention within the reproductive health framework, and there are many conflicts over which aspects of the larger agenda should be given priority, particularly in cash-strapped post-adjustment countries. The Tanzanian case study shows that the aftermath of structural adjustment and the economic crises that preceded it have wide-ranging effects on reproductive health. First, as I have argued elsewhere (Richey 2003a), an emphasis on combating the problem of overpopulation was linked with calls for economic restructuring, liberalization, and structural adjustment by Tanzania's donors and lenders. Consequently, concentrating on fertility reduction as the most important goal of population policy was promoted together with other conditionalities of reform. Second, the economic crisis of the state and reduced social sector spending limited the implementation of population policy primarily to family planning clinics.[2] Third, the experience of economic decline, vigorous family planning interventions, and limited provision of other social services affected health and development in the country. For example, Tanzanian men and women describe the harsh realities of economic decline ["*maisha magumu*" in Swahili] as reasons for wanting fewer children and using family planning. At the same time, they perceive health care to be declining and limited in scope, and access between families to be severely unequal. The reproductive health benefits of spacing one's children and more limited reproduction are well known, but it is often overlooked that the threat of poor reproductive health is used by service providers to convince women to use contraception. Thus, we see irony in the policy implementation in the clinics: poor reproductive health is used to restrict women's reproductive

choice. Poor reproductive health outcomes are blamed on the women who experience them, not on the social context or the health system that makes such outcomes likely.

Policy Successes and Failures in the Context of Neo-liberal Tanzania

The relationship between population policy and neo-liberal economic prescriptions has been addressed in a limited literature which concludes that structural adjustment, in general, is not congruent with the goals of population policy. But this literature, written when population policy was focused solely on fertility reduction, neglects the crucial role of development assistance in promoting certain kinds of population objectives. Grown (1994) called for an end to structural adjustment policies of the 1990s on the grounds that they would hurt population objectives by worsening poor women's economic status. Similarly, an earlier work focusing specifically on Africa (Palmer 1991) predicted that women in adjusted economies would be constrained into higher fertility through less participation in "market-oriented" activities.[3] From the line of reasoning in these arguments, in adjusted African economies, we would expect to see women wanting to bear more children who can contribute to the household economy and also increase their mothers' status. We would expect higher levels of desired fertility in countries that have undergone structural adjustment. Higher levels of desired fertility would be expected to lead to higher actual fertility and thus increased population growth (see Pritchett 1994).

According to the predictions, as the factors contributing to high fertility rose, women's access to contraception would diminish on account of "the increasing poverty of the Third World curtail[ing] the ability of governments and individuals to finance population programmes" (Grown 1994: 65; Palmer 1991). Similarly, Cornia et al. (1987) argued that cuts in the health care sector that accompany liberalization would result in decreased access to contraceptive and abortion services. However, these authors did not take into consideration that in cases like Tanzania, donors absorb nearly all of the costs of the National Family Planning Programme. The main donors funding the lion's share of the implementation of

Tanzania's National Population Policy are USAID and UNFPA. Therefore, it is critical to consider donor interests and willingness to pay, as well as government financing. In sum, while we would have expected from the studies on adjustment and population that fertility rates would have been maintained, if not increased, and family planning services would have become less available, in contrast, we have seen a clear decline in Tanzanian fertility rates and increase in availability of clinic-level contraceptives.

(a) Successful Family Planning

Contrary to the expectation that population policy implementation would be thwarted in the context of structural adjustment, Tanzanian implementation through its National Family Planning Programme claims a striking level of "success" if policy implementation is assessed on the criterion of fertility reduction. Regarding the demographic accomplishments of the National Family Planning Programme in Tanzania, an independent consultant of USAID was reported to have said about 1993 that "a miracle has been wrought" (United Nations Population Fund 1994, annex. E).

Family planning was offered in approximately 90 percent of Tanzanian health clinics by 1996. Between the early and mid-1990s, Tanzanian family planning use nearly doubled, and continued to rise slightly at the end of the decade. Rates of current use of any method by married women as documented by the Demographic and Health Surveys rose from 10.4 percent in 1991–92 to 18.4 percent in 1996 and 25.4 percent in 1999.

Knowledge of contraception is also quite high (in 93.5 percent of all couples, both know a modern method of family planning according to the 1999 Tanzania Reproductive and Child Health Facility Survey [TRCHS]) (National Bureau of Statistics Tanzania and MEASURE Evaluation 2000). Trends in fertility preferences have shifted during the period of the 1990s, with fewer married women wanting another child "soon" and more wanting no more children (1996–97 Demographic and Health Survey [DHS]) (Bureau of Statistics Planning Commission 1997b). The Tanzanian total fertility rate has declined over time from 6.5 percent according to the 1988 census down to 6.3 percent by the 1991–92 DHS, 5.8 percent by the 1996 DHS, and 5.6 percent by the 1999 TRCHS.

We do not know how much of Tanzania's fertility decline can be attributed to increased contraceptive use. Another cause of lower fertility

rates is infertility, higher in Tanzania than in neighboring countries.[4] Furthermore, Lloyd et el. (1999) argue that Tanzania still has lower levels of contraceptive use than expected when compared to other African countries with similar levels of educational attainment. However, it is not my point to assess the efficacy of the family planning program on fertility, but to point out that family planning has gone up at the same time as fertility has declined.

Therefore, the hypothesis that fertility decline could not take place in a structurally-adjusted context does not hold true for the case of Tanzania. In fact, my field research suggests that the economic hardship precipitated by structural adjustment and its related decline in social services may have led to a desire for fewer children.[5] This is different from the case of Uganda as we will see later in the chapter.

(b) Reproductive Health Failure: Poverty Constraints in Tanzanian Clinics

While the Tanzanian National Population Policy may be considered successful in meeting some of its goals regarding the distribution and use of contraceptives as shown by national level statistics, local level implementation shows that other important needs of women's reproductive health are not being met.[6]

In Tanzania, contraceptives are usually provided within an integrated clinic structure designed for family planning and maternal and child health services. This clinic may be situated within different types of health care structures: *(a)* a dispensary, the smallest type of health facility designed to serve a ward with a population of about 6,000; *(b)* a health center, with 20–30 beds that is supposed to function as a small hospital; or *(c)* a hospital, which may be classified as District, Regional, or Consulting. Private services are available for a fee from some church-based or NGO providers (such as the Marie Stopes or UMATI [the Tanzanian Family Planning Association]). Yet, three-fourths of all family planning users obtain their contraceptives from government sources (Bureau of Statistics, Planning Commission 1997a: 53), and more than 60 percent of all health services are provided by the government (National Bureau of Statistics Tanzania, and MEASURE Evaluation 2000). Thus, public service provision is still the most important source of Tanzania's reproductive health care.

While contraceptives became readily available at clinics during the 1990s, the health context in which they are delivered speak to overall deterioration of the Tanzanian health system. For example, blood pressure cuffs—critical for screening patients who may not be compatible with hormonal contraceptives and for problems in pregnancy—were available at the regional hospitals, but were absent from most other clinics, particularly rural ones. By the mid-2000s, these supplies were far more available, but service providers at a regional hospital complained that they were often breaking, a fact they attributed to their low quality, but this evidence was merely anecdotal. Lack of proper lighting, particularly for pelvic exams, is a serious problem for inserting intrauterine devices (IUDs) or conducting examinations. Clean water supply was a problem in all of the clinics researched in the 1990s. Even the regional hospitals, which were supposed to have running water from the tap, usually had to rely on buckets of water gathered from a shared water point in the hospital. This was not surprising considering that the matched national data available from the Service Availability Modules show both not only low, but also *decreasing*, percentages of government clinics with running water.[7] The national situation for electricity parallels that for running water: access to electricity *declined* in the 1990s, although the most recent data suggest that electricity access has improved by 2004–05.[8]

In my interviews with service providers, sufficient supplies were mentioned at every service provision site as a problem—particularly disposable supplies such as sterile gloves and bleach or other solutions for sterilizing instruments.[9] The chronic shortage was documented as early as the 1992 National Family Planning Programme Annual Report; the Ministry of Health wrote that "there was in all regions visited, an acute or chronic shortage of expendable supplies especially gloves, antiseptics, cotton wool, gauze, disinfectants and local anesthetic for minilap [female sterilization]" (United Republic of Tanzania, Ministry of Health 1992: 8). The problem had yet to be resolved by the end of the 1990s. In an interview, service providers in a health center expressed their frustrations over providing care in these circumstances:

> There is always a problem with bleach and gloves: they say that bleach is expensive and the government can't afford it, so usually we just use boiling because if we tell them [clients] to go and buy it they won't return. (interview with the author)

The lack of antibiotics in hospitals has been one of the most serious reasons for the country's high maternal mortality rate according to a Maternal and Child Health Regional Coordinator. The scarcity of antibiotics was confirmed by almost all service providers in interviews. A rural service-provider stated: "If you go to the regional capital for medicine, there isn't any—there are also no trays, scissors, nothing." I observed women who are diagnosed with reproductive infections being informed that the clinic had no medicine, and that they were supposed to go to the local pharmacy and buy antibiotics. I often heard women complain that they did not have money to purchase drugs.

By 2004, the resources for purchasing drugs and supplies had increased substantially at the district level. Revisiting a Regional Hospital, I confirmed that there is now water from an indoor tap, a functioning blood-pressure cuff, and the availability of basic supplies. Cost-sharing had also been implemented and a new sign outside displayed the costs of consultations and fees to be charged to patients. The staff of the Maternal and Child Health/Family Planning (MCH/FP) clinic explained to me that now they have more clients all the time, but fewer staff per department. Indeed, there were approximately 30 clients for family planning services on the day I visited and only one provider. I looked through their client registers and verified that this was indeed a typical day for the number of clients and providers in the clinic.

Proponents of a "reproductive health" approach to family planning argue that controlling one's fertility entails both preventing unwanted pregnancy and supporting healthy childbearing. Therefore, free antibiotics should be an integral part of providing for reproductive health. However, antibiotics have not been considered among the "family planning" supplies under the Tanzanian National Family Planning Programme. If women's reproductive health problems were diagnosed but not treated because of a lack of sufficient medicines, these women were, in effect, forced to continue with infections untreated. Untreated infections can lead to more serious reproductive problems, including infertility. A physician at a regional hospital elaborated during an interview:

> Many women have problems with infertility—far more than in the past—"hali ya maisha" [it is a fact of life] especially for young women. Many come to be treated only after they get complications—before, they treat STDs [sexually-transmitted diseases] themselves, sometimes using traditional medicine. (interview with the author)

The withdrawal of services and the worsening health that follows are used as a justification for more birth control.

Family planning is provided as the solution for health and development problems, and the prevalence of these problems in local communities is used to justify continuing a narrow focus on contraception. For example, one of the most common themes emerging from field research with family planning service providers in clinics was the use of reproductive health problems to create a need for family planning. In interviews with family planning service providers, I asked what they talked about when they did maternal and child health education, and whether they had ever encountered someone who did not agree with family planning. Responses across clinics were along the same theme that reproductive health problems *proved* that women needed family planning, not that poor health suggested the need for better health care. Five family planning service providers at a popular urban clinic in Morogoro Region said that they counseled about "high risk" (English terminology used in an otherwise exclusively Swahili context): "If you start with family planning and they don't understand the benefits, you tell them of the dangers and then they will agree!"

While there are certainly well-known benefits on women's health from child-spacing, presenting family planning as the solution to the larger problems not being addressed by the health care system shifts the responsibility for these problems to the women themselves who are at risk for suffering from poor reproductive health. It is not that service providers are malevolent, intimidating their female clients with the threat of health risks. It is rather that the National Family Planning Programme, limited to a focus on contraception and based on a narrow goal of controlling over-population, structures the environment in which these providers act.

The Future of Reproductive Health in Tanzania

The Tanzanian National Family Planning Programme needs to strike a balance between educating women about the relationship between family planning and good reproductive health, and providing a larger constellation of health services for the problems that contraception alone will not solve. However, macro-level factors, such as a population policy with a narrow scope of implementation and the impact of structural adjustment

at the clinic level, continue to plague attempts to promote a reproductive health agenda. The discourse shift from "population control" to improving "reproductive health" has been enmeshed in debate at all levels, but the ultimate characterization of this change as rhetorical or substantive must come from the women and men who are the intended beneficiaries of the policies, programs, and projects that follow from it. The Tanzania Reproductive and Child Health Facility Survey concludes that "in the field of maternal and child health, available data on mortality, morbidity, and nutrition suggest that only limited or no progress was made"; however, the next line notes "the greatest progress has been made in the field of family planning . . . ." (National Bureau of Statistics Tanzania, and MEASURE Evaluation 2000: vii). The reproductive health paradox in the post-conditionality context is that while contraceptive services are available and fertility is declining, overall health services remain poor and women's access to reproductive health care is limited.

Interventions aimed at improving Tanzanian women's reproductive health must be situated within the context of the country's current political economy. Economic crisis, structural adjustment, and post-conditionality are still defining the development landscape in Tanzania. Donor support will continue to finance substantial increases in public spending on primary education and health care. After the Cairo conference in 1994, the expanded agenda of promoting women's reproductive health should have been realized; however, development assistance for all sectors was inadequate to meet the challenges of overcoming the reproductive health paradox.

AIDS and Reproductive Health/Tanzania

In Africa, reproductive health has focused more on "reproduction" than on "health". National reproductive health programs in developing countries are implemented through the same structures of the old population policies. Reproductive health in many African communities might be best understood as remaining healthy enough to reproduce. When HIV/AIDS is at the center of women's lives—even though it is unspoken—and reproductive health services do not involve meaningful interventions for prevention and treatment, AIDS threatens to render meaningless the other important accomplishments of the reproductive health agenda. In this

context, Bangser (1999: 194) argues: "A renewed commitment to primary health care is perhaps the most critical need in Tanzania to establish a foundation for reproductive health."

An Annual Report from the Tanzanian Ministry of Health Reproductive Health Unit described a national situation where clinics are well supplied with contraceptives, but highly inadequate in providing reproductive health services (Tanzanian Ministry of Health Reproductive Health Unit National Family Planning Programme 1999).[10] Furthermore, sentinel surveillance data on the progress of safe motherhood revealed that the most common cause of death in women of reproductive age in their three surveillance areas during the 1990s was HIV/AIDS, accounting for 35–45 percent of all deaths to adult women (AMMP 2001: 6). In other work, I argue that HIV/AIDS prevention, treatment, and care needs only partially intersect with those of sexual and reproductive heath care and cannot merely be inserted into existing family planning programs, which have been re-named "reproductive health programs" (Richey 2003b). As for the critical reproductive health challenge that HIV/AIDS presents to the implementation of programs designed to prevent births, not disease, the last "main general finding" of the Tanzanian report states: "Integration of STI/HIV/AIDS in most of MCH/FP clinics has not been *started*" (Tanzanian Ministry of Health Reproductive Health Unit National Family Planning Programme 1999: 7, emphasis added). Most recently, a 2006 study found that family planning service providers almost never discussed sexually-transmitted infections, or HIV/AIDS prevention or testing (Jain et al. 2006: 30).

Throughout the course of my participant observation in maternal and child health and family planning clinics during the formative period of Tanzania's reproductive health program, I rarely heard about AIDS. I could, of course, visit any of the AIDS-related NGO projects—or in some cases, attend the separate STD clinic, or interview workers in the government AIDS Control Programme. But in the course of "normal" interventions of women's reproductive health, AIDS was confined to the section of "counseling for informed choice" about contraceptive methods: condoms prevent sexually-transmitted diseases like AIDS and other methods do not. Service providers were never shy about giving their clients health care advice, both solicited and unsolicited, but AIDS was not a topic for these conversations. Women came to family planning clinics because they

were "mothers", and sexuality and sexually-transmitted diseases were not "mother's" concern. Yet, AIDS remains *the* issue of reproductive health for many Tanzanian women (see Richey 2005). Furthermore, AIDS cannot be disentangled from the socio-economic struggles of women, who are also "workers" in the newly-liberalized Tanzanian economy.

In Tanzania, as elsewhere, men often make the final decision on condom usage, and men were almost universally absent from MCH/FP clinics. Indeed, as Farmer (1999) has aptly illustrated, the problem of AIDS is not a problem of ignorance about the virus, and not a result of the cognitive deficit of individuals. "We know that risk of acquiring HIV does not depend on knowledge of how the virus is transmitted, but rather on the freedom to make decisions. Poverty is the great limiting factor of freedom" (ibid.: xxv).

While policies are often aimed at providing free services, the implementation of these policies in the context of debilitated facilities is expensive, especially for the poor. For example, at the Morogoro Regional Government Hospital, maternal and child health services are officially free of charge. However, some services involve a monetary cost as explained by an attending physician during an interview: tubal ligation is free immediately post-partum for women who deliver in the hospital, but costs 1,500 shillings at other times; D&C is free, but clients must bring gloves (450 shillings per pair), and bleach (800 shillings); Cesarean delivery is free, but clients must bring sutures (1,500 shillings), IV Drips (1 liter 100–1,500 shillings), gauze (200 shillings per meter), iodine (450 shillings); normal delivery is free, but clients bring sutures (1,500 shillings), syringes (100 shillings each), egometrin (300–900 shillings), and gloves (450 shillings per pair). While the fees for each service appear small, Tanzanians regularly complain about their cumulative expense and about the uncertainty of how much money they might end up paying if they attend a clinic. These problems have worsened throughout the 1990s, and the proportion of births delivered in a health facility in Tanzania dropped from 53 percent in 1992 to 44 percent in 1999 according to DHS data. Rajani (2002) argues that the decline reflects the undermined confidence in the health system.

AIDS problems are most often dealt with in policies and projects that are seen as competitors for reproductive health funding, not as contributors to rethinking reproductive health policies and priorities. AIDS is a problem

of "lovers", while unwanted pregnancy is a problem of "mothers". Similarly, the insight of the reproductive health agenda—particularly the synergy between reproductive health, empowerment, and the right to health care—is not easily incorporated into the behavioralist models of HIV/AIDS interventions. The need to consider women's class position and men's gender roles in analyzes of international development to go beyond gender and development (GAD) has been pointed out by scholars of the past decade. Yet, we still hear most often of abstinence, anti-retrovirals, and condoms as the primary focus of AIDS interventions in Africa.

Petchesky (2000) argues that the indivisibility of rights is critical to thinking about women's health and empowerment. Yet, the historically-competing bureaucracies in family planning, maternal and child health, gender and development, and HIV/AIDS are not easily unified under the umbrella of "reproductive health". A population discourse dominated by concern for controlling fertility, whether by women, couples, or governments, precludes adequate incorporation of the challenges that AIDS brings to health care policy.

Health System Structural Constraints on Integrated Care

Why was the need to combat HIV/AIDS not having a synergistic effect on improving the health care system and boosting economic development in countries like Tanzania? There are both local and global constraints on providing reproductive health services to HIV-positive women. AIDS problems are most often being dealt with through policies and projects that are seen as competitors for reproductive health funding, not as contributors to rethinking reproductive health policies and priorities. Financial uncertainty, uncoordinated donor efforts, and tensions in the decentralization of service provision have led to stalled integration efforts throughout the Tanzanian health care system. (Oliff et al. 2003). Similarly, the insights of the reproductive health agenda, wedding reproductive health, empowerment, and the right to health care are not easily incorporated into the behavioral models of HIV/AIDS interventions.

One of Morogoro's most respected obstetrician–gynecologists surprised me during an interview when I asked her: "What is the biggest

gynaecological problem here in Morogoro?" and she responded, "People are lacking in education about family planning. They have seven or even eight children each." According to the 1999 Reproductive and Child Health Survey, in 93.5 percent of all couples both partners knew a modern method of contraception. Given the nearly universal knowledge of family planning in the country, I was surprised that this was *the* biggest problem she saw in her practice. Wanting to understand more about her work in other areas of reproductive health, I asked: "Which STDs do you treat most often?" Immediately she answered: "Syphilis," but then she stopped and added, "HIV, of course, is the highest, but it is just too much." Thus, syphilis and some gonorrhea could be treated, and condoms and other contraceptives could be distributed to her patients, but HIV was just too much.

Entrenched separate HIV/STD and MCH/FP vertical programs, common throughout Africa (Lush et al. 2001), cannot meet the needs of women in countries like Tanzania. On the other hand, HIV/AIDS cannot merely be inserted into existing family planning programs, renamed "reproductive health" programs. The reproductive health agenda can benefit from the lessons learned from years of trying to insert "women" into "development" though Women in Development programs. Ultimately, the conceptualization of the "problems" and "solutions" had to be changed, and the focus on gender has encouraged a rethinking of the meaning of development and the power relations that constitute who does development and for whom. HIV/AIDS must bring about an analogous paradigm shift within the reproductive health agenda—AIDS challenges us not just to expand the scope of the old population policies with interventions for tackling the disease, but to rethink the justifications for these policies, their primary actors, and their goals.

UGANDA

On the last day of January 2002, I sat in one of the large conference rooms at the Kampala Sheraton together with Ugandan Ministry of Health officials, most of the Ugandan Bureau of Statistics, representatives from NGOs, international donor agencies, and service providers. We were gathered to hear findings from the Ugandan Demographic and Health Survey (UDHS) on indicators of population, health, and nutrition. After

the usual official welcomes, the mission director from the organization that funded the survey reported findings that she termed "disturbing trends". The most prominent of these was that, although the overall prevalence rate of modern contraception had increased, there had been no decline in fertility, contributing significantly to Uganda's high population growth rate. According to the speaker, the "serious implications of rapid population growth" were linked to poverty, infant and child mortality, and immunization rates. Other disturbing trends in Uganda's health data were briefly mentioned, but the list—malaria, childhood diseases, poor antenatal care and unsafe deliveries, and girls' education—did not include HIV/AIDS. Although Uganda has been known for its AIDS "success", data still show that 5 percent of the population is living with the disease. The multiple linkages between HIV/AIDS and reproductive health were not part of the day's discussion. Findings were presented chapter by chapter, thus HIV/AIDS was discussed only when its time came in Chapter 11, the last presentation of the day. Today, reproductive health activists have reoriented debates away from population problems and toward women's health and rights. How then did "overpopulation"—not AIDS prevention or treatment, or women's empowerment, or the lack of health care—command the center of discussion at this meeting on reproductive health?

Missed Opportunities for Integration of Reproductive Health and HIV/AIDS Interventions

Treating AIDS and reproductive health as separate agendas is counter-productive to the promotion of women's reproductive health and rights in countries like Uganda. Both could be usefully integrated into the Cairo vision of reproductive health as a basic human right and the fundamental value of human agency (Freedman 1999). AIDS discourses and implementation strategies shape many aspects of reproductive health. First, AIDS has forced sexuality and gender into discussions that had previously been dominated by biomedical, functional explanations of how contraceptives could bring down population growth. Second, AIDS activists both nationally and internationally can be credited with expanding and promoting discussions of gender, including sexual and domestic

violence, marital relations and communication, and links between gender oppression and poverty. Similarly, campaigns for the rights of people living with AIDS and those who are HIV positive could be expanded to include the rights of all people to bodily integrity, including control of their reproduction and sexuality. Finally, AIDS activists' demands for adequate health care could be extended to include the right to health care for all illnesses, not just those that are HIV related.

One of the dangerous consequences of a lack of integration, as argued, by Baylies (2001), is that AIDS has made reproductive choice an illusion when women are not able to make meaningful decisions to protect their health and reproduction. One way that the vestiges of the fertility control agenda places women at risk of AIDS is when married women are discouraged from using condoms as contraception in favor of more effective hormonal means (ibid.: 2001). Furthermore, the successful promotion of condom use for AIDS prevention at times when one is neither abstinent nor faithful strengthens the method's association with illicit sex, thus making it unappealing to most couples in committed relationships (ibid.: 2001). Access to family planning services is limited in Uganda, and when women do receive services, it is not in an environment that supports women's decision-making. Clinic data from Kiboga District Hospital confirm that long-acting hormonal injections are by far the most popular contraceptive dispensed and one of only three methods available together with pills and condoms (Knudsen 2003). Offering female-controlled methods such as foam, gel, or the sponge is a missed opportunity for the health care system. A Ugandan study confirmed that women preferred these products to male condoms and that even when their use involved negotiation with male partners, women perceived them as empowering and enabling them to control their reproductive health (Green et al. 2001).

Uganda's Policy Responses to AIDS and Reproductive Health

The Ugandan HIV/AIDS policy's success has become ubiquitous. In the early 1990s, Uganda reported the highest infection rates in the world, with an estimated 15 percent of the population living with HIV/AIDS. Yet by 2001, the country had managed to bring the prevalence down to

5 percent (Hogle 2002). The greatest declines in HIV incidence are thought to have taken place in the late 1980s and early 1990s, and figures from Uganda's National AIDS Control Programme suggest that the prevalence and incidence of HIV/AIDS declined across all age groups and socio-economic levels (Kirumira 2001).[11] The country hosts one of the biggest AIDS care centers in Africa south of the Sahara, the Joint Clinical Research Center (JCRC) in Kampala, and was among the first recipients of the World Bank's Multi-Country HIV/AIDS Program I funding.[12] Uganda's policies on HIV/AIDS and reproductive health follow the same blueprints as those in most other developing countries. Yet thus far, the AIDS policies have achieved far more success than have any facet of the reproductive health policies.

Uganda's reproductive health policies have failed to reduce fertility levels, and they have been even less successful in improving many of the other aspects of reproductive well-being. A startling 22 percent of all maternal deaths are caused by unsafe, illegal abortions, and only 30 percent of all clinical facilities offered post-abortion care (Knudsen 2003). Only 21 percent of health centers at level three and above offer any level of emergency obstetric care (Orinda and Mbonye 2003). According to a Ugandan government report, "Infant mortality, child mortality, and maternal mortality have remained high and stagnant over the last 5 years in Uganda, in spite of good economic growth" (Ministry of Finance Planning and Economic Development 2002). Comparing data from the 1995 UDHS with those from 2000, we see a disturbing trend in most variables related to maternal and child health. Infant, neo-natal, and child mortality levels have risen, and maternal mortality has dropped slightly (from 527 to 505 per 100,000 live births). Fewer children with diarrhea were taken to any health unit for treatment, and the level of fully immunized children fell from 47 percent to 37 percent. Perhaps the most startling reproductive health indicator from these data is that the number of women delivering with the assistance of skilled health care providers has not improved significantly over the past 10 years, remaining at a mere 39 percent in spite of government targets for improved coverage (ibid.). Furthermore, only 5 percent of women gave birth in facilities equipped to provide emergency obstetric care (Orinda and Mbonye 2003).

The Ugandan state has been evasive in its population policy discussions, using its history of ethnic and religious cleavages to justify governmental

inattention at the national level (Kirumira 1998). Uganda's national family planning program dates back to the late 1950s, but Ugandan leadership has failed to see population policy as more than simply the equivalent of family planning. Some government representatives argued that Uganda had lost many people in the 25 years of civil unrest and the AIDS epidemic, so the population control policy was unnecessary (ibid.). International interpretation of the "population problem" (Hartmann 1995) has influenced program efforts in Uganda, and the emphasis placed on population control by international donors has set them against some Ugandan leaders. The NRM government did not express enthusiastic support for international population control policies that predated the Cairo conference, and it remains unclear how much it supports contemporary policies to promote reproductive health (Lane 1994; Presser 2000). Also, the politics of funding have led policy and program managers to support or develop programs that can attract quicker and better funding (Kirumira 1998).

In 1995, however, Uganda endorsed a National Population Policy whose goal is "to influence the future demographic trends and patterns in desirable directions in order to improve the quality of life and standards of living of the people" (Government of Uganda 1999). This policy is supposedly being expanded to incorporate the post-Cairo vision of reproductive health. In 1999, the Ministry of Health developed a minimum Reproductive Health Package to reflect national priorities (Ministry of Health 2001b). This vision can be understood through the goals of the Reproductive Health Division of the Ministry of Health: to increase the contraceptive prevalence rate from the current 15 percent to 30 percent, to reduce the total fertility rate from 6.9 to 5.4 percent, to increase the percentage of supervised deliveries by trained personnel from 38 percent to 50 percent, to strengthen reproductive health manpower [*sic*] capacity in all districts, and to improve the Health Management Information System (HMIS) for routine monitoring of reproductive health services in 45 districts as well as at the national level (Ministry of Health 2001a). Preventing or treating HIV/AIDS is conspicuously missing from these original reproductive health goals, but its absence was noted in a Reproductive Health Division publication (Ebanyat 2002).

In May 2001, the National Policy Guidelines and Service Standards for Reproductive Health Services was adopted to address all the components of reproductive health: safe motherhood, family planning, adolescent

health, prevention and management of unsafe abortion, reproductive tract infections (including STDs and HIV/AIDS), infertility, cancers, obstetric fistulae, and gender-based violence (Ministry of Health 2001b). These guidelines have a specific policy objective: "to integrate the management of STI/HIV/AIDS into all reproductive health services and to strengthen existing strategies to reduce mother-to-child transmission of HIV" (ibid.). In practice, however, it is not clear that these policies are being implemented, and the guidelines themselves are not well circulated, even among Ministry of Health workers in Kampala. One informant questioned the possibility of implementing 13 strategic objectives when the basics of health care are not even in place. Cynicism over the possibility of translating policy into genuine concerns for women's health continues; as one district medical officer put it, "The Ministry of Health does not care about anything other than their Pajeros (fancy cars) and their allowances. They don't care about women" (Tripp 2000).

Ideology, International Funds, and Approaches

Implementing the components of Uganda's reproductive health agenda requires adequate funding, particularly for those programs less likely to be supported by donors. As a quintessential post-conditionality regime, there is a mutual dependence between donors and the Ugandan state. Donors are eager to see states like Uganda succeed in order to justify their own policies and choices made in international development assistance. In Uganda, it may be that such success has distracted both the government and its donors, causing them to turn a blind eye to the vast improvements needed in public health care.

Although there is no question that Uganda has been portrayed as *the* AIDS success story among a field of poor performances, the search continues for answers to *how* Uganda has managed to lower its infection rates while most other African countries have been unable to. Many different approaches, implemented through various agencies under diverse and sometimes even conflicting strategies, have been at work in Uganda since the early stages of the epidemic. The resulting success has been claimed by proponents of each strategy as "proof" that their approach is the way

forward in the fight against AIDS. The American popular press and some politicians have embraced one strand of the Ugandan approach—Abstinence, Be faithful, use Condoms (ABC)—and tried to sell it as a more effective, less costly public health strategy compared with condom promotion and safe-sex education. One USAID official is quoted as saying that "the historical approach to HIV has been little A, little B, and big C. The public health community at large did not believe in abstinence, but Africans were far ahead of the public health community on this . . . The core of Uganda's success story is big A, big B, and little C." (Pitts 2003). However, the claimed success of ABC was based on questionable evidence (Shuey et al. 1999) and this does not reflect the actual approach to HIV/AIDS in Uganda, which has included multiple approaches. It is unlikely that any single component alone could have achieved what the multiple strategies accomplished. "Love Faithfully" would not have been possible without the alternative of "Love Carefully". Two studies, one funded by USAID and the other by the Alan Guttmacher Institute, compared changes in variables representing the A, B, and C approaches from nationally representative UDHS and Global Programme on AIDS (GPA) surveys. Both studies concluded that "changes in all three of the factors investigated—abstinence, monogamy, and condom use—probably contributed to lower risk of HIV infection, at least for some women and men and some age and marital groups" (Singh et al. 2003).

Misrepresenting the Uganda model can have policy implications that are dangerous for Ugandan women, however. For example, the potentially harmful effects of abstinence and fidelity-only messages for women are never noted by conservatives. Critics have pointed out that messages such as "be faithful" or "stick to one partner" can actually increase the vulnerability of women who mistakenly believe that their own fidelity will protect them from contracting HIV within a long-term relationship (Quarraisha 1998; Tallis 2002). HIV prevalence rates for sub-Saharan African women peak at around 25 years of age, which means that the majority of women are contracting HIV within marriage, and three recent studies have shown that more than 80 percent of women who were infected with HIV were monogamous (Center for Health and Gender Equity 2004). Yet, even if married women realize that they may be at risk of HIV, their options for self-protection within their marital sexual relationships are limited.

The societal expectation that women must be sexually available to their husbands on demand and the high rate of violence and sexual coercion within marriage put women at high risk of HIV, and this has not been adequately addressed by the Ugandan state or its donors (see Karanja 2003). Raising the issue of condom use within marriage can increase a woman's risk of violence, and exiting a violent marriage is likely to expose women to other relationships of sexual risk, when they are not "protected" by a regular partner. Although the current US Global AIDS strategy claims to draw lessons from Uganda, it misrepresents the country's comprehensive effort against the disease in ways that could undermine, rather than support, Ugandan efforts.

Dilapidated State of Public Health Care

In the mid-1960s, Uganda boasted one of the best health care systems in Africa, consisting of "an excellent national referral and teaching hospital and a hierarchy of government health units and district hospitals, as well as many mission-run facilities" (Whyte and Birungi 2000). However, between 1976 and 1988, the number of patients attending government health units fell by half. Years of war, economic decline, and structural-adjustment-related cuts left Ugandan public health in ruins.[13] A recent Human Rights Watch report argued that the private sector, NGOs, and community-based organizations have begun restoration of health services together with the government, but that inadequate medical supplies, lack of trained staff, and limited access for Ugandans living in rural areas still prevail (Karanja 2003). The 2000–2001 Annual Report from the Reproductive Health Division listed the following constraints: reduced staffing, inadequate funding, lack of supplies such as contraceptives and "maternal drugs", insufficient fuel and maintenance funds for division vehicles, and a dearth of communication and computer facilities. Research conducted by the Delivery of Improved Services for Health (DISH) project noted that inadequate supplies and frequent stock-outs of STD drugs, condoms, and contraceptives, together with a lack of basic equipment and clinic expendables, discourages use by clients who see no reason to travel long distances to attend poorly equipped health units (DISH 2003).

A large proportion of Ugandans with STDs either treat themselves at home or seek care from private practitioners instead of using the public health clinics (Walker et al. 2001). Lack of trust was the reason patients gave for avoiding these clinics in favor of private practitioners. The private providers said that their clinics were more conveniently located, had longer open hours, and provided private confidential consultations, so they were more trusted in the community (ibid.). Furthermore, both the providers and patients emphasized the importance of personal relationship, developing a good rapport, politeness, and trust—all cited as lacking in the public clinics. The issue of cost was discussed in the study, and although public clinics are theoretically cheaper, the lack of medicines and constant demand for informal "payments" to every health worker encountered makes receiving treatment at public facilities a similarly costly endeavor (ibid.).

Scaling Up: Challenges for HIV/AIDS and Reproductive Health

The Ugandan government signaled a positive shift in its policy by agreeing to increase health sector spending with money it receives from the Global Fund (Wendo 2003). The new flow of funds should be used for the purchase of antiretroviral drugs and for improving medical infrastructure. Yet, the difficulties of wedding decentralized service provision with improving access for poor people are likely to increase with the integration of AIDS treatment as part of Ugandan's health care expectations. Kivumbi and Kintu (2002) examined the government's attempts to place "safety nets" in the form of exemptions and waivers of user fees for health care. Qualitative data from the districts of Mukono and Mbarara showed that district local governments had little motivation to extend exemptions to their constituents, as they were more interested in raising revenue to meet recurrent costs of service provision than in providing equitable access to health care (ibid.). Yet health equity is particularly important for improving reproductive health outcomes, as providing health services even to the majority of the population may still not reach those persons at highest risk of maternal, infant, and childhood death (Erickson 2003).

Uganda has been noteworthy for its decentralized approach to scaling up levels of voluntary testing and counseling for HIV/AIDS (Contact Group on Accelerating Access to HIV/AIDS-related Care 2001). The Ministry of Health was recently restructured at the behest of international donors to comply with decentralized development policy. Jeppsson et al. (2003) analyzed this restructuring and concluded that although the foundation has been laid for the Ministry of Health to function in its new role as coach more than a player, the move toward a functioning relationship between the ministry and service-delivery levels is still incomplete. Effective policy responses to the new realities of AIDS treatment will require a well-funded, capable state with goals of health equity. These are the same requirements for implementing the other aspects of the reproductive health agenda. In spite of a new recognition that a "capable state"[14] is needed, the foundation for improving state capacity has been overwhelmingly eroded through the neo-liberal policies of the past 20 years and their corresponding neglect of the state in favor of NGOs.

Consequences of Dilapidated Public Health Facilities on HIV/AIDS

The ongoing impact of HIV/AIDS on the already overtaxed and under supported state health care system takes many forms. One of the less obvious ones is, ironically, the result of AIDS-prevention campaigns. Birungi (1998) described how the dilapidated state of the Ugandan public health services has led to a loss of trust in the treatments these clinics offer. This skepticism, coupled with anti-AIDS education campaigns warning people against the dangers of sharing unsterilized needles, has led Ugandans to engage in medical "self-help". Birungi shows how injection technology (syringes, needles, and injectables) has been domesticated and personalized in Uganda, as people want to receive injections under their own control from people whom they trust at home. Although the culture of the injection in Uganda and other parts of Africa has historical roots in colonial medicine (Vaughan 1991), the AIDS epidemic and its prevention campaigns have joined with a dysfunctional health care system to intensify personal injection practices as part of health care in contemporary Uganda.

The extent to which unsafe medical procedures are responsible for transmitting HIV in Africa has been the subject of intense debate. An US study estimated that nearly one-third of new HIV infections in Africa were likely to have been caused by infected needles, not sexual encounters (Brewer et al. 2003; Gisselquist et al. 2003; Gisselquist and Potterat 2003); however, these figures were immediately disputed by UNAIDS (UNAIDS/WHO 2003). Although the heterosexual transmission of the epidemic in Uganda has not been called into question, the relationship between inadequate health care and transmission is an important issue.

HIV interventions were able to succeed in spite of the constraints in the health care system because of HIV's status as a health emergency and because the behavioral and educational focus did not demand the same level of infrastructure as other reproductive health needs did. Providing health care services is not sufficient to enable women to improve their reproductive health; they must be able to exercise their reproductive rights in practice as well. However, as HIV/AIDS care shifts to include treatment, a health care system that promotes reproductive health and rights will be necessary for success in Uganda. Uganda's historically NGO-oriented approach to AIDS is unlikely to meet the challenges of the new phase of the epidemic.

As treatment becomes increasingly central to AIDS in Uganda, leadership and commitment to accessible health care delivery systems will be necessary to integrate AIDS into a reproductive health care approach and to upgrade reproductive health systems to successfully deal with AIDS. Treatment activist organizations in Uganda as in other parts of the Third World are creating demand and raising expectations that AIDS is a treatable disease. Barnett and Whiteside (2002) have suggested that AIDS has many lessons to teach us not only about preventing and treating the disease, but also about health, well-being, and development. "It may be the epidemic that enables us to respond to the need for a common global public health." In Uganda, AIDS and reproductive health have existed as artificially separate agendas competing for funding and attention. Because of their different goals and scope, the two agendas could be implemented in different ways: AIDS through decentralized, multiple targeted strategies promoting change in sexual behavior and reproductive health through improved medical service provision.

CONCLUSION

Human rights should provide the foundation for a new generation of integrated policies that promote healthy sexuality, informed and consensual reproductive choices, and the development of the individual and her or his society. AIDS policies and reproductive health policies come with their own histories, stakeholders, and agendas, however, and the points of conflict and cohesion between them must be understood so that policy rhetoric and material interventions move toward an integrated vision of promoting basic human rights.

Given that the predominant mode of HIV transmission is through heterosexual intercourse and that childbearing is almost universal in both Tanzania and Uganda, a meaningful reproductive health agenda must serve men and women and address gender inequality while incorporating HIV/AIDS. Together, AIDS prevention and treatment, reproductive health services, and family planning based on choice not imposition form the minimal interventions necessary for promoting a reproductive health and rights agenda in both countries. Educating women to demand their rights of bodily self-determination and creating institutional contexts in which these rights are respected are necessary for both women's fertility choice and sexual decision-making.

The reproductive health paradox in post-adjustment health care, as demonstrated by the realities of East African clinics, provides important contextualization for understanding the results of reducing aid in the health sector, while increasing it in the population sector. Given that Tanzania and Uganda, like most post-adjustment countries, are heavily reliant on donor aid to finance health care, donor priorities are likely to have direct implications for clinics. Ironically, in light of the calls for expanding population policy into larger areas of reproductive health care, the proportion of aid designated for health has declined. The most dominant trend among donors is the shift toward funding that targets sexually transmitted diseases and HIV/AIDS. If money given for HIV/AIDS is taken out of the calculation of funding, then health has actually declined as a share of ODA, from 5.4 percent in 1993 to 5.0 percent in 2003 (MacKellar 2005: 308). Donor initiatives make up 68 percent of all funds, public and private, spent on AIDS in developing countries for 2005—60 percent more than the 8 percent share agreed upon in Cairo in 1994 (van Dalen and Reuser 2005: 36).

Infrastructure, employment, training, and supervision of health care workers, accessible supplies including but not limited to pharmaceuticals, and integrated policies for achieving health equity are necessary for improving sexual and reproductive health and for continuing to meet the HIV/AIDS pandemic with success. Although domestic policy and management factors are necessary, in resource-poor countries they are not sufficient means for providing health services. Financial commitments must be forthcoming from international donors, particularly to countries in which needs are great and public health leadership has been proven. However, national leadership, both to promote Ugandan as well as Tanzanian policy objectives and to instill confidence among international donors that it is worth investing in these countries, will continue to be important for domestic health care. Political reform, including meaningful strategies toward openness and democratization, would expand the possibilities for Uganda's women's organizations to support more politically challenging issues such as those of reproductive rights. Priority setting, direction, and coordination will be necessary to a greater extent than in the past, even though promoting a diversity of approaches could be helpful in implementing an agenda as wide ranging as Cairo. Again, this requires comprehensive planning at the government level. Expanding health care access for all Ugandans and Tanzanians will be critical for achieving further success in reproductive health.

We are at a critical juncture when the "problem" of HIV/AIDS is being reformulated in a rapidly changing context of multi-national pharmaceutical companies, plummeting life expectancy, and promises from donor countries. At this time when problems are being delineated, there may be an opening for critical, fieldwork-based contributions to become "policy relevant". What is at stake here is whether we permit inquiry to reduce HIV/AIDS to "life style" and "behavior"—in the words of Farmer, "Is gender inequality a 'life style'?" (recounted in Hunt 1997). After more than two decades of devastation by the disease, the impact of HIV/AIDS is starting to be taken seriously in analyzes of African "development". There is a need in contemporary academic scholarship for theoretically grounded social science research at the geographical interface of global discourse and local interpretation.

The contemporary "conference wisdom" that improving health is the way forward for economic development should call into question any

reproductive health policy whose focus and outcome is not improved health. The reproductive health paradox of increasing contraception in the context of ever-worsening health care demonstrates both the potential successes of vertical, donor-reliant initiatives, and their considerable failures. The reproductive health agenda is vast and expensive, but it arises out of the struggles of women for adequate access to quality health care that respects their human rights. However, as AIDS treatment activists have continued to stress, "expensive" is a question of political priorities, and integrating HIV services within programs providing other sexual and reproductive health interventions should offer cost savings (Askew and Berer 2003). Grounding these interventions in a framework of human rights brings attention to both the gender disparities and geopolitical inequalities at play (Stein 2000). This assumes that AIDS should neither be left out of reproductive health nor allowed to subsume all of its resources.

NOTES

1. Other post-conditionality states identified are Ghana, Mozambique, Cote d'Ivoire, and Cameroon.
2. I will not attempt to lay proportional blame on the policies of structural adjustment in isolation, as we have no way to know the extent of the decay caused specifically by the limitations of economic restructuring versus the problems caused by economic decline itself. That Tanzania's health care system has seen a severe decline since the early independence system is, however, quite clear.
3. Palmer explains the relationship between adjustment's effects and continually high levels of fertility when "deterioration of women's economic status, by leading to further uncertainty, locks women even more tightly into survival strategies which emphasize fertility and dependency" (Sadik 1989 cited in Palmer 1991: 4). The links between fertility as a means for achieving women's status in Africa have been well documented in work such as Oppong (1989) and Youssef (1982).
4. Higher levels of infertility in some regions may be partly responsible for the appearance of a lower total fertility rate (Larsen 1997).
5. Larsen (1997) and Kamuzora (1991) similarly suggest hardship-related fertility choices in Tanzania.
6. The bulk of the analysis presented here is based on data collected during fieldwork in Tanzania for 18 months in 1995–96, again for six months in 2000, and during dissemination trips in 2002 and 2004. The primary data include interviews with family planning service providers and key informants, focus group discussions with women of reproductive age, and a survey of married couples of reproductive age, all conducted by the author in Swahili. Qualitative data based on fieldwork conducted in 10 service provision sites (equally distributed between urban clinics in the regional capital cities

and clinics in the villages at varying distances from the cities) in the three study regions are analyzed together with quantitative national level survey data. They were chosen to represent areas of high (Kilimanjaro), average (Morogoro), and low (Ruvuma) rates of contraceptive use, and clinic sites were chosen in consultation with district and regional health officials to reflect a variety of service provision scenarios. Kilimanjaro represents a best-case scenario with a long history of high-quality public and private service provision. Morogoro is a more average region with relative accessibility to the Tanzanian capital and a number of donor-supported projects, but without the history of affluence and donor investment seen in Kilimanjaro. Ruvuma is a more challenging context for health care in general and family planning in particular, as it has historically been one of the "forgotten" localities for both government and donors, due in part to its distance from the capital.

7. The percentage of government hospitals in the matched sample had electricity, but in 1994, only 85 percent had it. For health centers, 24 percent had electricity in 1991, and 23 percent in 1994; while in dispensaries, 15 percent had it in both the 1991 and 1994 samples (Ngallaba et al. 1994: 7–10). In the 1999 facility survey, they asked only about facilities using treated water, and only 15 percent of all government facilities at any level had treated water (National Bureau of Statistics, Tanzania, and MEASURE Evaluation 2000: 22). A 2006 survey, also measured different variables, but found that 35 percent of dispensaries still relied on water from an unprotected well, river or roof rainwater catchment (Jain et al. 2006: 12).

8. In 1991, 87 percent of government hospitals in the matched sample had electricity, but in 1994, only 85 percent had it. For health centers, 24 percent had electricity in 1991, and 23 percent in 1994; while in dispensaries, 15 percent had it in both the 1991 and 1994 samples (Ngallaba et al. 1994: 7–10). The most recent facility survey did not ask about electricity, but did note that less than 1 percent of government dispensaries had a working light source, laboratory or refrigerator (National Bureau of Statistics, Tanzania, and MEASURE Evaluation 2000: 24). 2004–05 data show 28 percent of dispensaries with electricity, and hospital levels again reaching 90 percent (Jain et al. 2006: 12).

9. The implications of these shortages for the spread of infectious disease should not be disregarded.

10. According to the report "Contraceptives availability in most of the units was satisfactory. Most of MCH/FP units were found to have shortage of basic equipment/supplies, that is, BP machine, thermometers, weighing scales, examination bed/coach, sterilizers, antiseptic cotton wool gauze, and maternity pads" (Tanzanian Ministry of Health, Reproductive Health Unit, National Family Planning Programme 1999).

11. Kirumira points out that HIV/AIDS prevalence and mortality figures are inherently subject to error and he gives a fair assessment of the data limitations. Still, his conclusion is that the decline is "real" although the measurements may be imprecise (Kirumira 2001).

12. The $500 million Multi-Country HIV/AIDS Program (MAP) for Africa is one of the largest potential funding sources for access to HIV/AIDS treatment. This fund provides loans for HIV/AIDS prevention and treatment with an emphasis on vulnerable groups, communities, and civil society organizations in Africa.

13. An issue of the Uganda Health Bulletin from the Ministry of Health was published on the theme "The Paradox of Uganda's Poor and Worsening Health Indicators in the Era of Economic Growth, Poverty Reduction and Health Sector Reforms" (Ministry of Health 2001a).

14. Challenges to the development of a capable state in Africa involve strengthening the components of democracy, facilitating the role of civil society organizations in development, rebuilding the capacities of failed states, and strengthening economic governance through enhanced institutional and human capacity for sound and efficient public management (UN Economic Commission for Africa 1999).

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12

China's Population Policies: Engendered Biopolitics, the One-child Norm, and Masculinization of Child Sex Ratios

Susan Greenhalgh

State birth planning became a nationwide political and institutional reality in China in the 1970s. Since then, every pregnancy has been designated as either planned and legal (*jihuanei shengyu*) or unplanned and thus illegal (*jihuawai shengyu*). Since 1979/1980, birth planning has been virtually synonymous with the notorious one-child policy. Both popular media and scholarly literature have generally portrayed Chinese population politics as an unending and violent struggle between a coercive state and a fiercely resistant society that continues to this day (Aird 1990; Scharping 2003; White 2000; Zhou 1996). These accounts neglect three important features of the politics of population in China. First, by focusing solely on the state's repressive project of drastically limiting population numbers, they have overlooked the second, more seductive, project of enhancing the "quality" of the Chinese people. The politics of quality, which is now the major domain of population politics in the country, has been very different from that of quantity. Second, and in part because of this omission, standard accounts have missed important transformations that have taken place in China, especially since the early 1990s, as neo-liberalizing marketization has accelerated within the country and intersected with the focus on population quality. Finally, focusing only on the negative effects of the population programs, conventional accounts have

overlooked the positivity or productivity of power, which has given rise to new or transformed sites of struggle and new kinds of subjects.

NORMALIZING REPRODUCTION: STATE SCIENCE AND LOCAL CULTURE

Most of the existing work on China's population politics is grounded in the Western liberal tradition, in which power is viewed as concentrated in the state and as fundamentally negative or repressive. In this chapter, I draw on a different body of theoretical work—Foucault's work on biopower, or the calculated power over human life—to present another account of China's population politics and its effects. In his seminal study, *The History of Sexuality*, Volume 1, and in later lectures, Foucault proposed that the modern political era (in Western Europe beginning in the 18th century) has given rise to a new form of power that is no longer concentrated in governmental institutions of the state but is instead increasingly dispersed throughout society in disciplinary institutions such as medicine, education, and the law, and in self-governing individuals themselves (Foucault 1978). Grounded in modern science and technology, whose claims to authority rest on their apprehension of and mastery over nature, this modern power over life focuses on and works through the body. This power over life operates at two interconnected poles: the regulations of the population as a whole, and the disciplines of the individual body. Modern power is not only negative and repressive, but also positive and productive, producing new forms and sites of politics and new subjects that are useful to modern societies and economies. This work on the politics of life has exceptional relevance to China, the world's most notable case of the rapid politicization of population, and a case in which regulation has encompassed not only the quantity of population but also its quality.

Our story about China begins in the central state, with the views held by the leaders of the People's Republic of China (PRC) of their agenda and of what they believed was at stake in the creation and imposition of tough new norms on China's people. The post-Mao population project of the PRC has been part of a larger endeavor to modernize the country rapidly through selective absorption of Western science and technology. After the depredations of the Cultural Revolution, class struggle was dead,

Marxian ideology moribund, and the party's reputation nearly ruined. The modernizing Deng regime that came to power in 1978 sought to rebuild the regime's legitimacy by transforming it into a scientific modernizer that would lead the nation to the long-promised wealth, power, and global position.

Population policy was a key site for the construction and expansion of this new scientific authority rooted in nature, biology, and the body. Population was an opportune site for the development of the scientific state because the core constructs involved in its management lent themselves well to definition in biological terms. Reworking a broad set of putatively "scientific" discourses on sexuality fashioned in the early 20th century, the post-Mao state defined these constructs—population (the quantity issue), race (the quality question), and gender (the instrument of reproductive management)—in starkly biological terms (Dikotter 1995, 1998; Evans 1997). Population was represented as a biological process of reproduction of individual organisms aggregated into a larger population. Race, often conflated in the Chinese discourse with nation (*minzu*), was construed as a biological entity to be enhanced eugenically to promote fitness and competitiveness of the national "organism" in a social Darwinist world of interracial and international competition (Sigley 1996). Finally, gender difference was defined as biological difference in reproductive structure and function, with women being the primary reproducers. The use of these biologized constructs allowed the state to represent these forces of great potential—and of great threat—as impersonal processes "in nature" that had to be "objectively" investigated and managed by the state "in the interests of the nation as a whole". Through the use of modern population science and reproductive technology, the regime would take charge of these domains, creating a population of optimal size and characteristics that would both facilitate and symbolize China's status as a rising global power.

Drawing on two closely-related natural sciences borrowed from the West, population cybernetics and the population ecology of the Club of Rome, the PRC regime defined China's problem of population in the crucial transition period of 1979–1980 as a dual crisis: too many Chinese of too backward a type (see Greenhalgh 2008). The solution was for the state to construct and energetically promote new norms guiding the production and cultivation of modern persons. The ultimate aim was to transform

China's backward masses into a scientifically normalized, modern society (see Bakken 2000). Through the scientific control of population, Deng era reformers saw an opportunity to present China as a global good citizen, a nation that would contribute to the world's welfare by controlling the growth of the world's largest population (at the time, one billion people). The People's Republic would limit its numbers not through coercion, but through the socialist means of propaganda and education.

To this end the post-Mao regime sought first to limit the growth rate of the population (*shaosheng*) and then to enhance its physical and mental quality (*yousheng*). Mobilizing a variety of human and life sciences, including demography, developmental psychology, sexology, and reproductive biology, to contribute to this new project on life, the state established putatively "scientific" norms of quantity and quality. The state and the disciplinary agents of the medical, educational, and other professions then worked to promote, persuade, mobilize, or otherwise induce local society to adopt these norms.

The natural science that produced the new one-child norm defined social and cultural factors as irrelevant. Yet it was China's social structure and culture that gave local society the community reproductive norms that it would staunchly defend against the supposedly scientific norms of the state. Two aspects of popular culture, especially peasant culture, proved crucial: a gender logic that accorded males more value than females; and an economic logic of intergenerational exchange within the family. When the party tried to enforce its culture-free (or culture-modernizing) policy on a Chinese society—labeled as "feudal", "backward", and "small-minded"—these logics asserted themselves with great vigor, impressing themselves on the politics, policy, and effects of the PRC's population project at both local and national levels.

During the long 1980s (roughly 1979–1993, henceforth simply "the 1980s"), the dominant norm promoted by the state was one child for all. Because this quantitative norm was set far below societal desires, it was at root negative, or repressive. For years, and still today in many areas, efforts to instill that norm were fundamentally coercive, involving state use or threat of force (physical, legal, or otherwise) to impose it on society. In an era in which nature and science were the new grounds of authority, it was the biological reproducer, the reproductive-age woman, who became the object of state control. The bodies of women—in particular,

married women aged between 15 and 49—became public sites of intense struggle over an array of reproductive issues (contraception, the timing of reproductive events, and the number and sex of children) that had long been matters of family politics but were now swept up into the maelstrom of state politics as well. Women's bodies became the target of intense surveillance, intervention, and control.

In China's son-loving culture, the struggles over the number of children soon became contests over the sex of those offspring—and infant bodies and fetuses became a second site of fierce struggle. Although population planners did not intend to put infant girls at risk, this was the inevitable consequence of a policy that allowed only one or two children while neglecting the gendered nature of personhood in Chinese society. Enforced in an increasingly masculinist culture and socio-economy of the reform era, the sharp restrictions on childbearing have had damaging, even lethal, consequences for infant girls.

In this chapter, we trace at the community level the broad transition from Leninist, or state-centric, to increasingly neo-liberal, or market-driven, biopolitics, beginning with the struggles over population numbers in the villages and then turning to the conflicts over quantity and quality in the cities. I examine both the negativities of this new power over life—the damaging human and bodily consequences—and the positivities or productivities. The rise of biopower in China brought about the emergence of new sites of struggle and of three new types of subjects essential to the success of the population project: the reproductive woman charged with lowering the birth rate, the single quality child, and the good mother tasked with raising that superior child.

CREATING ONE-TO-TWO-CHILD FAMILIES IN THE VILLAGES: THE LONG 1980s

When the state launched its one-child policy in 1979–1980, its overriding objective was to create one-child families in the countryside, where roughly 90 percent of China's one billion people lived. If that goal could be achieved, policymakers believed, the problem of population numbers would be largely solved. Yet the norm of one child for all was profoundly out of touch with the central role of children in the peasant household

socio-economy and the gendered nature of personhood in Chinese culture. Virtually all studies of the childbearing preferences of China's peasants in the 1980s found the same thing: a fervent desire for two children and a lingering preference for three. As important as the number was the sex: at least one of those children had to be a son (Davin 1985; Greenhalgh and Li 1995; Scharping 2003; Whyte and Gu 1987; Zhang 2002).

Throughout China's agrarian history, the peasant family has been the central unit of social life, essential to the socio-economic security and mobility of its members. Despite the collectivization of rural life and the socialist promise of welfare for all, Maoist policy privileged the cities in the distribution of resources, leaving the peasant family to continue playing central roles in the provision of old-age support and in production on private plots (Parish and Whyte 1978). The Deng reforms of the late 1970s and early 1980s dismantled the collectives, privatized health care, and virtually abolished the minimal provision for old-age social security, making the family once again the core unit of production and welfare.

Within the peasant family's social and moral economy, children have long played crucial roles specified by an implicit set of exchanges between the generations. Parents provided for the economic welfare of their children: support in childhood and adolescence, training for productive and/or reproductive work, and dowries for daughters and property at the time of family division for sons. Children reciprocated by contributing to the family economy and sons supported the parents in old age. As part of their filial duties, sons also had to pay respect to the ancestors and perpetuate the family line. Because of the patriarchal, patrilineal, and patrilocal nature of the Chinese family, personhood in Chinese society has long been gendered in such a way that boys were the children who counted. Only a son could fulfill the duty to carry on the male-centered family line. Because sons would remain with their parents after marriage, parents invested more heavily in their upbringing and education with the expectation that they would support their parents well in old age. In the absence of public forms of social security and in a rapidly changing environment, sons were the vital and irreplaceable keys to economic security and, indeed, the very survival of the family. For girls, who would join their husbands' families at marriage, the inter-generational contract called for lower educational investments. Yet girls still had important roles to play in helping with housework and childcare. Shaanxi villagers I worked with cherished an

image of later life in which their married daughter would come home to do the cooking, do the laundry, and keep them company with stories of village affairs. It was the daughter who would ease the pain of old age by providing emotional comfort and bodily care.

These life-and-death stakes from the villagers' perspectives set the stage for a highly confrontational politics of population. In the early 1980s, the first phase of the one-child policy produced a politics that turned out to be gendered, corporeal, and even deadly. When the state sought to impose its new one-child-for-all norm on the countryside, resistance took myriad forms, from forging documents to concealing pregnancies, bribing officials and doctors, refusing to pay fines, publicly cursing birth cadres, hiding with relatives, finding foster parents for unauthorized children, fleeing in advance of campaigns, migrating to carry a pregnancy to term and later, joining communities of "birth planning guerrillas" who had escaped to the geographic margins to have babies (Wasserstrom 1984; Zhang 1982).

With successful policy enforcement defined as fulfillment of targets for births and birth control procedures, women's reproductive bodies became the central site of political struggle on a massive, society-wide scale. The reproductive-age woman, far from being nurtured as a self-governing subject, was subjected to relentless, sometimes brutal, state control. Assigned tough targets, village-level cadres focused their energies on the corporeal tasks that would prevent more babies from being born: aborting unauthorized pregnancies, getting women with one child to undergo IUD insertion, and sterilizing one member of couples (invariably the wife) with two or more children. Many women resisted these pressures at the corporeal level—illegally removing their IUDs, undergoing fake sterilizations, and so on—giving rise to a new politics of the body that would have serious consequences for their health.

In 1983, national political and program leaders launched the first of what would be many nationwide crackdowns on births. Local cadres were assigned impossible targets and quietly authorized to use any means necessary, including force and late-term abortions, to achieve them (Qian 1989: 132). Where officials were instructed that "all actions that control population are correct", pregnant women were treated like the enemy. According to one Hong Kong reporter, big-bellied women were put in cowpens, handcuffed, and escorted to operating areas by armed personnel (Lo 1981). Another reporter observed women locked in detention cells

or hauled before mass rallies and harangued into agreeing to abortions (Wren 1982). When officials in some places insisted on aborting and even sterilizing women with no sons, peasant couples, fearing the end of their families, physically attacked the birth cadres. Peasants desperate for another chance for a son also abandoned their baby girls, leaving them in cardboard boxes for others to find or, when a final solution seemed preferable, suffocating them or throwing their bodies into village wells (Croll 2000; Yan 1983). The situation was so serious that *People's Daily*, seeking to stop the violence, warned in early 1983 that "at present, the phenomena of butchering, drowning, and leaving to die female infants … have been very serious" (Li and Zhang 1983). With such grim developments, the infant body too became a new site of political struggle.

Fearing serious instability in the countryside and even further damaged relations between the rural masses and the regime, in early 1984 the party center effectively acceded to peasant demands by authorizing the addition of exceptions to the one-child rule. This resulted in the evolution of new, more lenient, informal policies at the local level that were invariably male-gendered because of villagers' demands for a son. In three closely observed Shaanxi villages, for example, all couples were allowed to have two children, including one son, in exchange for women's agreement not to press for more. Women who followed the local rules were exempted from the harsh contraceptive requirements of the political center, an exemption that disappeared once they "caused trouble" by getting pregnant outside the plan (Greenhalgh et al. 1994).

Policymakers in the provinces reacted to these local policy innovations and political pressures by formally expanding the conditions for second children to include the gender of the first. In 1988, the political center itself modified the formal reproductive norms so that rural couples whose first child was a girl could have a second (Zeng 1989)—a clear engenderment of formal policy. Through this "mass-line" process, peasants pressed their most urgent reproductive need—a son—on the state, leading to a peasantization of national population policy. The bottom-up preferences of local society came to shape central policy, and then that modified, now gendered, policy was reimposed from the top-down on local society. In this way the masculinist values of the peasantry became firmly embedded in national policy during the 1980s. Far from being a minor rule change, the official adoption of this slightly relaxed "daughter-only" (*dunuhu*) or

1.5-child policy, which remains the official policy in the early 2000s, had broad political consequences. It not only differentiated between urban and rural, creating different rules for each; it also distinguished between male and female, giving formal, indeed legal, recognition to the unequal value of son and daughters.

Unfortunately, the relaxation of policy and enforcement in the mid-1980s, combined with shifts in age structure that brought huge numbers of women into childbearing age, led fertility to climb sharply in the late 1980s. This prompted a tough re-enforcement of birth planning and reimposition of the now "stabilized" 1.5-child policy in the early 1990s. The early 1990s was a tense and terrible time in the history of birth planning, despite the official prohibition on the use of coercion. In Shandong and Henan, campaign posters virtually incited the use of force with such mottos as: "Treat birth planning [offenders] as landlords were treated during the Land Reform" and "Deng Xiaoping says that any method that reduces fertility is a good method" (Interview conducted by the author on December 16, 2003 in Beijing).

Images of the "feudal", "backward" peasant whose excess childbearing and low quality were undermining the nation's modernization helped to justify the use of dehumanizing, at times almost barbaric, methods to bring rural population growth under control. The evidence of widespread resort to physical force during the birth planning campaigns of the early 1990s is not just credible; it is overwhelming because it comes from top officials in the birth commission itself (Interview conducted by the author on November 23, 1999 in Beijing). Whether real or partly doctored from below, as local officials cheated their superiors with false numbers (Zhang 2002), the statistics showed that fertility fell markedly in the early 1990s, dropping to about 1.8 in 1993. The campaigns of the early 1990s thus marked the beginning of the end of the decade-long era of strong-armed state imposition of its norms and violent confrontation over rural childbearing.

SOCIAL SUFFERING IN THE VILLAGES

Throughout the 1980s and 1990s, the official discourse on population highlighted the intended achievements of birth planning—births averted,

contraceptive prevalence attained, and so on—while neglecting both the human costs borne by the targets of control and the unintended problems that developed when a demographically ambitious, putatively gender-neutral, program interacted with a deeply gendered culture and society. Yet the target-driven birth planning of the 1980s and early 1990s seriously impaired the physical health and emotional well-being of substantial numbers of rural Chinese women. The harsh enforcement of the birth policy built on the larger anti-peasant sentiment of the post-Mao years to create a deep urban-rural divide in bodily pain, family trauma, and social suffering.

For China's rural people, being targeted for forceful surgery was a deeply traumatic experience. The campaigns of the early 1980s and early 1990s spread terror and panic in the villages, as those targeted for birth control surgery contemplated the loss to the health of their bodies and families that would soon ensue (Huang 1998; Ku 2003). Especially intense fears surrounded the prospect of sterilization. That operation brought not only the permanent end to one's reproductive capacity but also, villagers believed, the loss of vital essence, *qi*, and, in turn, the dissipation of sexual vigor and energy to work (Mueggler 2001; Potter and Potter 1990). Exacerbating women's dread of the operation was the fact that most sterilizations in the 1980s and early 1990s were performed during rushed campaigns, when outside medical teams spent short periods in local areas conducting surgeries en masse, often without adequate facilities, sanitary equipment, or anesthetic medicine.

Compounding the bodily trauma was the degradation rural women and their families suffered in the birth planning campaigns. In the worst of the mobilizations, they were treated no better than farm animals. Indeed, villagers in some places ignored the official term for sterilization, *jueyu*, insisting on *qiao*, the term for spaying female animals, especially pigs (Mueggler 2001; Yan 2003). In some times and places, rural women were taken by force, placed in cages, and transported to quasi-public operating areas, where one after another they had their tubes tied or IUDs inserted without anesthetic. When beds were in short supply, the ground was used instead (Weisskopf 1985; Interviews conducted by the author on November 22, 1999 and December 12, 2003 in Beijing; Mueggler 2001). Some medical practitioners suffered as well when they were required to violate both professional and human ethics by conducting mass

surgeries in substandard conditions, aborting fully developed fetuses, and administering lethal injections to unauthorized newborns (Nie 1999; Weisskopf 1985).[1] Though the vicious campaigns are now gone, they live on today in frightening dreams and embodied recollections that only students of historical memory can retrieve.

Aggregate statistics show that Chinese women have borne the great burden of sterilization and contraception, and that burden has grown over time. Of the four-fifths of one billion operations (male and female sterilizations, abortions, IUD insertions, and removals) performed from 1971 to 2001, 95 percent were performed on women. That proportion has increased every half decade to 98 percent in the late 1990s and early 2000s. The ratio of female to male sterilizations rose especially dramatically between 1990 and 2001, from 3.6 to 6.1. Beneath these gendered numbers lie pervasive cultural attitudes affirming male superiority, male entitlement to sex, and male prerogative in protecting the body from risk.

Overall, the birth program has left rural women with short- and long-term physical problems and with deep psychological wounds that reflect and worsen their low status in the male-dominated culture of village China. One major source of health problems has been contraceptive failure, experienced by roughly one-quarter to one-third of women, virtually all of whom must undergo an abortion (1997 Reproductive Health survey cited in Jiang 2000: 145; see also Xie et al. 2000). During these years, almost three-quarters of abortions were related to contraceptive failure, many to the cheap stainless steel IUD that the program relied on for many years (Cheng Yimin et al. 1997; Kaufman 1993; Luo et al. 1999a, 1999b). Although abortions have greatly declined from their early 1990s peak, other problems are not reflected in the overall number of procedures. One is the high incidence of repeat abortion (and IUD insertions), which worsen the risks of infection and perforation (Kaufman 1993; Li Bohua 1999). Another is the prevalence of late-term abortions, widely used in the campaigns of the 1980s and early 1990s to eliminate unauthorized pregnancies. A 1997 government reproductive health survey—the first to be conducted since the launching of the one-child policy—suggests that one-fifth of abortions are done in the fourth month or later (Chu 2000). Finally, abortions in China are generally performed without anesthesia, causing what women describe as pain so unbearable it is like having one's heart cut out (Zhou et al. 1999; Interview conducted by the author on December 12, 2003 in Beijing;

Nie 1999). In several studies conducted in the early 1990s, both women and their doctors described abortions as often physically and psychologically agonizing experiences that leave many deeply anxious about having sex (Gui 1999; Zhou et al. 1999). There are also long-term consequences for women's reproductive and general health from inappropriate, botched, or repeated birth control procedures. In the 1997 survey, 69 percent of women argued that abortion affected their physical and mental health, with one-quarter of those indicating that the effects were very serious (Jiang 2000: 131). Yet because of the political dangers associated with criticizing the birth policy, the subject of abortion has been surrounded by a "nameless fear" that has kept both women and their doctors from speaking out about these traumas (Nie 1999: 235–60). Far from feeling entitled to good health, women felt that their biology, which renders them inherently more "sickly", made it their destiny to suffer more than men in the domains of sexuality and reproductive health (Chu 2001; Evans 1997; Xiao et at. 1995). In placing women's bodies at risk, the birth program has thus reflected and worsened a pervasive view of women's inferiority.

Compounding these problems is the physical abuse—from beating to, more rarely, poisoning and strangling—that women have sometimes suffered at the hands of son-hungry husbands (Honig and Hershatter 1988; Lee and Kleinman 2000). Wife battering remains an entrenched feature of rural Chinese life (Pickowicz and Wang 2002). The physical and emotional strain has led some village women to take their own lives. Young rural Chinese women have been committing suicide at an alarming rate, 66 percent higher than that of rural men (Pearson et al. 2002; Phillips et al. 2002). Some of these deaths have been tied to problems associated with birth planning. The psychological costs of a stringent birth policy enforced in a male-centered society are simply immeasurable.

Even without precise measurement, it is clear that the human and bodily costs of rapid, essentially coerced, fertility decline have been enormous, and unevenly distributed in such a way that it has been the most powerless members of Chinese society—rural women, infant girls, the not-yet-born—who have endured the most. Since the mid-1990s, the birth commission has sought to change course and make women's health and overall well-being a more central objective of the birth program. Although the quality of reproductive health care is improving, much remains to be done, especially in the areas of contraceptive choice and counseling.

The feminization of birth control surgery underscores the urgency of today's efforts to spread the burden of contraception more evenly (for example, SBPC 15 May 2002).

MARKETIZATION AND MASCULINIZATION: THE 1990s AND EARLY 2000s

Despite an unbending policy and the inescapability of birth planning, both local officials and ordinary peasants have reported that tensions over birth planning in the more developed rural areas began to ease significantly in the late 1990s and early 2000s. Promoting this happy development was a major decline in the number of children villagers wanted. As the 1980s wore on, desires for three children waned, giving way to a near-universal preference for two children—one son and one daughter (Greenhalgh and Li 1995; Zhang 2002). By 2001, a national survey suggests, the rural ideal had shrunk further to 1.79 children, and an amazing 49 percent of rural women aged 20 to 24 indicated that a one-child family was their ideal. By the late 1990s and early 2000s, some young newlyweds were opting to stop at one, even if that one was a girl (Xie et al. 2000; Yan 2003; Zhang 2003).[2]

Behind these transformations in reproductive culture lay decades of insistent propaganda and practice that assigned the right to decide the number of children to the state. Young couples marrying from the mid-1990s onwards had grown up with birth planning as part of the ambient political culture. Just as culturally transformative, however, were the profound changes in family life brought about by deepening marketization, urban migration, and the spread of urban consumer culture. To rural people throughout the country, the issue that loomed largest was that of child economics—the escalating costs and vanishing benefits of children (Yan 2003) imposed by the "discipline" of a rapidly developing market. Unlike the 1970s, when the arrival of a new child was rewarded by the state with extra rations and land (Parish and Whyte 1978), in the marketizing economy of the 1980s those incentives disappeared. Meanwhile the costs of raising children climbed rapidly—costs not only of bare essentials, such as food and clothing, but also of schooling, health care, weddings, and a new category of "incidental expenses" (*linghuaqian*) defined as necessary to

enhance the bodies and minds of their youngsters: nutritional supplements, purchased snacks, educational toys, extra lessons and more. Although children continued to contribute to the family economy, changes in the rural economy (declining plot sizes and a growing labor surplus) coupled with declining parental control over young people's incomes (a result of earlier family division and urban migration of youth) greatly reduced that contribution (Yan 2003).

At the same time, the advantages of having children declined. The biggest concern of many rural parents has been the growing unwillingness of sons to honor their most fundamental obligation: to support them in old age (Yan 2003; Zhang 2004). As time passed, increasing numbers of rural parents found themselves virtually abandoned by their sons and fearful for their futures in an environment with neither social security nor health insurance (ibid.).

Behind the widespread decline in filiality lay the erosion of the male-centered intergenerational contract, the foundation and cement of Chinese peasant family life. The socialization of the means of production during the collective era had already weakened the reciprocal bond between parents and sons by depriving parents of their major economic contribution to their sons, the family's landed estate. Marketizing reform greatly accelerated the process by handing resources and power to the young, including to young daughters-in-law, who succeeded in precipitating ever-earlier family division (Judd 1994; Selden 1993; Wang 2004; Yan 2003). The escalating costs and declining benefits gave rise to a radically new discourse on children. Far from the longstanding view that "many children bring much wealth" (*duozi duofu*), children were now deemed heavy economic burdens (*fudan zhong*).

After years of struggle, in which peasants had impressed their son preferences into state fertility norms, the rapid marketization that began around 1993–1994 has seen a (partial) convergence in norms, in which couples in some areas have begun to embrace the official one-to-two-child norm as their own. The acceptance of the new norm has been aided by a newfound appreciation of the value of daughters, a result in part of the growing unfiliality of sons. Already in the 1980s, some parents were expressing definite desires for daughters, seeing them as more emotionally caring than sons and gaining value in the labor market of the reform economy. By the late 1990s and early 2000s, village parents in some places

were actively cultivating their daughters as emotional and even economic caregivers in old age (Murphy 2002; Yan 2003; Zhang 2003). These cultural changes are promoting a less conflictual politics of population in many villages today. In some localities, birth planning is becoming more genuinely voluntary, people's wishes are shaping their contraceptive and fertility practices, and rural women are becoming self-governing reproductive subjects (Chang 2001; Merli et al. 2004; Yan 2003; Zhang 2002). After 20 years of struggle over the planning of birth, both China's rural people and observers of Chinese population politics can breathe a sigh of relief.

But the easing of tensions among the living has been achieved at the cost of spreading violence against the not-yet-born and growing masculinization of Chinese society. The new national policy adopted in the late 1980s required villagers with a son to stop childbearing and allowed those with a daughter to have only one more even if it too was a girl. This gendered state norm, forcefully reimposed in the early 1990s, did not so much ease the gender problem in a rural society, in which most couples wanted one son and one daughter, as push it back into the period before birth.[3] The politics of quantity produced a new site of reproductive struggle—the fetus—and a new politics of fetal gender and life.

From the early 1980s, peasant couples had reluctantly begun disposing of their second and third daughters in a desperate attempt to get a son. Although outright infanticide seems to have declined during the 1980s (Croll 2000), infant abandonment persisted. Babies have been abandoned on street corners, in hospitals, on piers, in markets—any place they might be found and taken in by new caregivers. The abandoned children were overwhelmingly healthy girls with no brothers, or with one or two sisters. Research in the 1990s suggests that perhaps as many as half of those children who were abandoned died before being found. Those who found their way into state-run orphanages or hospitals may not have survived either. Because the children often arrived in a fragile condition, and state-run welfare homes have generally been understaffed and under-funded, mortality rates in these institutions have been extremely high, averaging perhaps 40 to 50 percent of children and soaring to 90 percent in more remote areas (Johnson 2004: 38, data from early 1990s). From the early 2000s, however, abandonment appears to be declining and conditions in many welfare homes are improving (Hutchings 1997; Li and Zhu 2000; Zhongguo 1989).

By the 1990s, if not earlier, a second wave of struggles centered on the fetus began to overwhelm the first. From the mid-1980s, the spread of ultrasound-B machines into every corner of rural China introduced a new and improved way to ease the conflict between state and family fertility norms. For growing numbers of Chinese couples, prenatal sex determination followed by sex-selective abortion has become an attractive, indeed, a "modern" high-tech, alternative to the crude and morally fraught disposal of already-living infants in order to stay within state limits on child numbers while achieving their gender preferences (Kristof 1993). Today, the practice of prenatal sex detection followed by sex-selective abortion is certainly the single greatest contributor to a growing dearth of girls. By the turn of the millennium, the abortion of female fetuses had become a thoroughly normalized practice in the villages in some areas of the country (Chu 2001; see also Xie et al. 2000). While solving an old gender problem, it has created at least two new ones, one bodily, the other ethical.

Because fetal sex cannot be detected with accuracy until the fourth or fifth month of gestation, women undergoing sex-selective abortion must have the procedure late in pregnancy, when health risks are higher. Many women have said that they strongly preferred sex-selective abortion to infanticide, abandonment, and even adoption out—practices that, they feared, would produce guilty consciences at best and divine punishment at worst. Aborting their fetuses avoided these problems because the fetus was not yet a person. Yet sex-selective abortion produced moral qualms of its own. The vast majority felt that aborting girls was wrong because it "destroys life" and "treats girls unfairly" (Chu 2001: 274). Roughly 50 to 60 percent of those interviewed in three central China villages believed that life starts before birth, while 25 percent felt that to abort was "equal to killing a human being" (Nie 1999: 118, 124). Enveloped in public and private silence, this moral disquiet is one of the many uncharted costs of enforcing a tight population policy in a still-patriarchal society.

Since the late 1980s, the central government and, in turn, many provinces, have issued countless notices and legal provisions forbidding the use of ultrasound for sex determination (Chu 2001). Yet with governmental control over society declining, such bans have proven impossible to enforce at the local level, where bribes and personal connections have more force than law. With the proliferation of private clinics offering

sex-detection services, and ultrasound technicians exhibiting as much bias as parents, the situation seems to be beyond government control.

As a result of these and other practices,[4] the sex ratio at birth has climbed steadily. By the turn of the millennium, it had soared to 120 boys per 100 girls—the highest in the Asian region and in the world. (The biologically normal ratio is 105 to 106 boys for every 100 girls.) Birth planning, in conjunction with China's male-centered culture and market economy, has masculinized the social order, making a big gender gap in numbers a constitutive feature of Chinese modernity.

If the effects on gender valuations and the population structure are worrying, the larger societal consequences of the loss of female bodies and lives are formidable. The first wave of such effects has cropped up in the shortage of marriageable women. By around 2010, demographers estimate, the marriage market for first marriages will be seriously imbalanced and by 2020 about 8 percent of men, or roughly one million individuals, will be unable to find brides (Tuljapurkar et al. 1995; Yuan and Skinner 2000). The gender gap in marriage is creating major social problems for poor men and women. In border provinces, the shortage of brides has been met by importing women from Vietnam and Korea. In poor interior provinces, the shortage of marriageable women has given rise to cases of informal polyandrous unions (*yiqi duofu*) in which the wife of one man informally "services" several others. Increasingly since the mid-1980s, the urgent need of poor peasant men for brides has been met by the development of clandestine smuggling networks involved in the long-distance buying and selling of women and adolescent girls (*maimai hunyin*) (Demick 2003; FEER 1989; Han and Eades 1995; Zhuang 1993). Despite central and provincial government efforts to stop the trafficking in women, given the persistence of pockets of deep poverty in rural China, the abduction and sale of marriageable women may well worsen as the high and rising sex ratios of the 1990s translate into even more serious shortages of brides in the future.

Even if it increases no further, the highly skewed sex ratio at birth of today will have huge and distorting effects on China's culture, society, and polity that are scarcely imaginable today (Hudson and Boer 2004; Yang 2004). Since its introduction, the one-child policy has been promoted as a policy requiring sacrifice today for the benefit of "generations of come". Yet the legacy that the PRC's birth planners will leave to those

future generations is mixed at best. That legacy includes a widespread devaluation of the feminine, the tight attachment of women to a broad array of reproductive tasks, and large distortions in the population structure that will haunt planners, policymakers, and ordinary people for decades to come.

CREATING ONE-CHILD FAMILIES IN THE CITIES: THE 1980s

In the cities, the conditions of urban life gave rise to a much less confrontational politics of population numbers. A combination of people desiring fewer children than in the countryside and increased state control over urbanites' lives both limited popular resistance to the one-child policy and enabled birth cadres to enforce it by the preferred means of "propaganda and education".

In the 1980s, the majority of urbanites, like many of their rural counterparts, wanted two children (though city residents expressed no interest in having three) (Feng and Zheng 2002; Scharping 2003; Whyte and Gu 1987). But a different constellation of child benefits and costs limited the number of children that parents felt able to raise well. The social and economic values of children in the cities were lower than in rural areas while the direct and indirect (or time) costs of raising children were steeper—and rising. In the 1980s, as prices of basic necessities climbed, the state and work units cut back on social supports while cultural expectations about the ingredients of proper childrearing grew ever more demanding. In the cities, sons were less vital to family welfare, survival, and old-age security because parents supported themselves through wage-labor jobs that provided pensions. By the end of the decade, growing numbers of women were saying that they had the time, money, and energy to raise only one child (Milwertz 1997: 127).

These features of urban family life made it easier to enforce the one-child norm, but enforcement was also eased by the tight networks of control through which the regime managed the urban population. Even after the introduction of a private sector, the great majority of urban people remained employed in state-controlled organizations (Tang and Parish 2000). Couples' structural dependence on their workplaces, which provided not only jobs but also housing, health care, pensions, and other

essentials, made active resistance to the one-child rule, if not impossible, then prohibitively costly—violation of the policy might bring loss of job and all that went with it. Supplementing the vertical control of the workplace was the daily, horizontal surveillance achieved by the street or residential neighborhood, whose "granny police" of voluntary enforcers kept an eagle eye out for anomalous behaviors and tracked down the noncompliant (Burns 1985; WuDunn 1991b).

These mechanisms of control permitted birth cadres to enforce the one-child policy through institutionally and ideologically produced "voluntarism", which involved the creation of "socialist reproductive subjects" with disciplined bodies and accepting minds. At their workplaces, women were subject to tight surveillance and control of their reproductive lives, with everything from their premarital health to their marital status, monthly periods, contraceptive practices, and pregnancies subject to close monitoring and mandatory management (Rofel 1999). Over the 1980s, after an initial period of hostility to the new norm, women came to the politically "conscientious acceptance" (*zijue jieshou*) of the state planning of one-child families (Croll 1985; Milwertz 1997; Wolf 1985). Women's tolerant attitude toward micromanagement of their bodies stemmed in part from their acceptance of the official line that China faced a crisis of human numbers that was sabotaging its development, necessitating a policy of one child for all (Milwertz 1997; Nie 1999: 131–39). By the early 1990s, if not sooner, the notion of the one-child family had become a staple of urban reproductive culture. As the urban environment made child-raising ever more costly and challenging, women became increasingly self-governing reproductive subjects who limited their fertility of their own in a way that accorded with state norms.

The urban and rural politics of population numbers that unfolded during the 1980s thus differed in systematic ways. Both forms of politics were corporeal and gendered, centering intensely on the control of the female reproductive body. In the cities, however, because meaningful resistance was virtually impossible, enforcement could rely on "ideology" rather than coercion. Although urban women were subject to structural or institutional coercion applied persistently over their reproductive lives, they escaped the violent crackdowns imposed on the peasantry. The urban politics of population also had a different temporality. Unlike rural policy enforcement, which grew severe and lax with cycles of coercion

and resistance, the urban pattern of meticulous control and "voluntary" compliance was more stable. These two patterns of politics also produced differences in birth policy—a 1.5-child (or daughter-only) policy in the villages and an ungendered one-child-for-all rule in the cities. Since the mid-1990s, however, a combination of forces—massive rural-to-urban migration, the spread of urban consumer culture, the decline in rural child-bearing desires, and important shifts in the birth program itself—has led to some blurring of the rural-urban distinction.

FROM QUANTITY TO QUALITY

In the 1990s and early 2000s, while the birth commission continued to devote substantial attention to restricting quantity, the enhancement of population "quality", has become increasingly central to the politics of population. From the beginning, the state's effort to restrict population numbers was intimately linked to guaranteeing the "quality" of the next generation. Launched in the late 1970s, the eugenics campaign—*yousheng youyu*, literally superior birth and childrearing—embraced a broad and eclectic array of scientific research programs, state policies, and social activities promoting top-quality health care and education for the young (Bakken 2000; Champagne 1992).

For the birth planning establishment, promoting the quality child was necessary for China's competitiveness in the global marketplace of the future. As a popular text on the education of the single child put it, under conditions of economic and political competition in the 21st century, China's entry into the world requires a large pool of superior talents (*youxiu rencai*) with world-class education based on modern science and technology and up to international standards (Wu 2003: 86–88).

State emphasis on quality both tapped into and further provoked parents' anxieties about whether their one (or, in the villages, two) offspring would not only survive but also grow into healthy, well-educated, competitive young adults able to succeed in a rapidly changing society and provide for them in old age. Far from suppressing people's desire, the emphasis stimulated it by taking advantage of widespread parental aspirations for the upward mobility (and future filiality) of their one (or two) children.

If the one-child norm was repressive, the norm of the healthy, educated single child was highly seductive.

In the urban areas, state and parental investments in the bodies and minds of the young began to grow rapidly in the 1980s when the single child became the "sun" around which all planets revolved (Wren 1982). In the 1990s, when China's consumer economy intensified and the quest for the perfect child became a veritable national obsession, investments in the young exploded (Tyler 1996; WuDunn 1991a). Growing preferences for one-child families only contributed to the intensified focus on creating perfect offspring.[5]

By contrast, in the late 1980s and early 1990s, the rural population was more likely to be labeled "low in quality" and targeted for heavy-handed eugenic improvement and numerical control through the sterilization of those designated "unfit" and "drains on society" for "genetic" reasons (Dikotter 1998; Johnson 1997; Pearson 1995). Although the eugenic impulse has remained strong, the prevention of "defective" births has absorbed much less energy than the promotion of "quality" births. By the 1990s, state and parental efforts to upgrade child quality through the enrichment of child nutrition and education had become increasingly prominent features of village life as well (Greenhalgh et al. 1994; Jing Jun 2000c; Murphy 2004; Zhang 2003).

The shift from quantity to quality as the central arena of population politics marks a profound transformation in the nature of population power and politics in China. This metamorphosis from Leninist to increasingly neo-liberal biopolitics has involved three crucial trends. First, the shift from quantity to quality has introduced a new type of norm and a new form of population regulation. While the quantity norm was fundamentally repressive, requiring continued, often coercive, state enforcement, the quality norm is seductive, coinciding with sky-high popular aspirations for the next generation. State imposition of its norms on parents has been accompanied, and even replaced, by enthusiastic self-regulation by parents emphasizing individual imperatives to raise their children according to the new popular norms on health and education. Indeed, the quality project has become a major site for the creation of the sorts of self-regulating, "autonomous" neo-liberal subjects desired and assumed by both the marketizing quasi-capitalist economy and the slimmed down neo-liberalizing state.

Second, in the politics of quality, power has come to center on two new or reconfigured objects of societal investment and control: the "good mother", who disciplines her body and embraces scientific mothering practices; and the "quality child", whom she cultivates but who also fosters his own bodily and mental capacities—both neo-liberal subjects par excellence. (I discuss the production of these new subjects in the urban areas in the following paragraphs.)

Third, the emphasis on quality has expanded the number and range of authorities promulgating child health and education ideals, leading to the rapid development of professional/disciplinary power over people and the emergence of the market as a major force disciplining individual desire. While the birth commission and its science advisors were virtually the sole authorities on population quantity, the authorities on child health and education are many and diverse, ranging from traditional Chinese medical and religious authorities to other agencies of the state (especially the medical and educational bureaucracies), to international organizations (such as WHO and agencies of the United Nations), to Chinese and transnational corporations. Each is striving to define the standards for child health and education and to convince parents (and children themselves) to adopt their standards and related practices and products. As population quality becomes the object of attention of growing numbers of social forces, then, the power to shape Chinese lives is drifting away from the state's birth planning establishment. The growing role of capitalist corporations, and of market logics of consumer desire and global fantasy more generally, is part of a larger neo-liberalization of Chinese population politics.

PRODUCING THE "GOOD (=SELF-SACRIFICING AND SCIENTIFIC) MOTHER"

From the initiation of the one-child policy, the birth program targeted mothers as the key creators of the superior child. Focusing initially on newlyweds, birth planning workers and other agents of the state actively promoted "eugenic" (healthy) births to encourage adherence to the one-child rule (Evans 1997). Through pre-marital and pre-natal testing, medical workers sought to prevent genetically problematic marriages and eliminate

"poor quality" embryos. In the mid-1980s, eugenic efforts were broadened to include the health and education of the only child. Through mandatory parenting classes, the media, knowledge contests and other means, the birth program instructed mothers in scientific methods of bodily improvement (feeding, illness prevention, and so on) and intelligence enhancement. These efforts were supported by a popular literature of books, magazines, and newspapers instructing parents, especially mothers, on techniques for the production of "superior" children (Champagne 1992).

Broader currents in the culture and economy actively supported the state's efforts to turn mothers into dedicated and skilled nurturers of their single children. In the early 1980s, there was renewed political and cultural emphasis on women's domestic roles—and corresponding de-emphasis on the work roles that had been so prominent under Mao (Jacka 1990; Robinson 1985). As part of the broader scientization and biologization of politics and society, the emphasis on gender similarity and equality of the Maoist years gave way to a stress on gender difference and inequality located in the body (Evans 1997; Woo 1994; Yang 1999). Differences in reproductive physiology were now said to dictate a new division of labor grounded in "nature" in which women's roles and identities were based largely on their activities in the domestic domain. In the early 1980s, when a tight labor market became increasingly hostile to women workers and led to widespread calls for women to "return to the kitchen", the traditional notion of the "virtuous wife and good mother" (*xiangi liangmu*) was officially revived and reinforced to encourage women to take those domestic roles seriously (Honig and Hershatter 1988; Hooper 1998).

With modern parenting defined as scientific parenting—where "scientific" denoted authoritative more than based on scientific research (Champagne 1992: 41–43)—and parenting meaning largely mothering, raising a single child expanded into a demanding and complicated endeavor. By the early 2000s, if not before, parents were expected to teach their youngsters not only arithmetic, Chinese characters, the arts, and emotional intelligence, but also English, a crucial skill for the 21st century. With all these responsibilities on their shoulders, mothers of single children reported devoting more time, energy, and money during the 1980s and 1990s to perfecting their one child than their own mothers had spent nurturing several youngsters (Milwertz 1997).

Many women actively embraced their new roles as family nurturers who sacrificed their own needs for the sake of their children. They did so not only because the economy now devalued their paid labor and the culture tied women's worth to those reproductive and caregiving roles, but also because of their own intensified needs to ensure support from a child in old age. Although most city couples could expect pensions, those pensions were becoming inadequate (Unger 1993), and pensions for women were especially limited. A child, however, was irreplaceable as a source of emotional support and, even more so, practical help, especially when illness or physical disability set in (Ikels 1996; Milwertz 1997). Far from reducing the need for a child in old age, changes brought about by wage reforms, mandatory retirement, the reduction in pensions and state subsides for health care, and the growing geographical mobility of children worked to reinforce the importance of family support for the elderly (Fong 2004; Ikels 1993; Whyte 2003). Moreover, with only one child, it became an urgent matter to ensure that the child would be willing to honor his or her filial obligations. Mothers aimed to cultivate gratitude and indebtedness in their child, so that the child would reciprocate with financial support, health care subsidies, and nursing care later on.

Today, women have fewer children than in the past, but every aspect of reproduction—from spouse selection to marriage, contraception, childbearing, and childrearing—has become the object of intense state concern. The effect has been to further publicize activities that, in pre-communist days, belonged to the more private sphere of kinship, making them more salient in the lives of individuals, families, and communities. Moreover, the sheer amount of time, energy, and resources now required to bear and rear children have turned childrearing into a demanding, time-consuming and money intensive prospect. At the same time, the reform economy has brought active discrimination against women in the labor market. Since the early 1980s women workers in the cities have faced large-scale layoffs, low wages, and segregation in lower-paying jobs and sectors (Jacka 1990; Robinson 1985). Given the limited nature of the jobs generally available to women, especially in the cities, many may find the nurturing of a child more rewarding than their jobs and invest more of their energies and selves in it. Despite the sharp decline in fertility, the subjectivities of many women during the reform era in China appear to have become more rather than less closely tethered to their reproductive roles and responsibilities (Hooper 1998; Milwertz 1997).

NURTURING THE "QUALITY (=DISCIPLINED, CONSUMERIST AND GLOBALIST) CHILD"

The ultimate goal of all these efforts was to create a new generation of planned, "quality", largely single children equipped to participate in the globalized economy, society, politics, and culture of China's future. In the 1980s, the birth program propagandized and promoted health and education, but soon other government agencies began actively promoting child health and nutrition through the development of nutrition surveys and the establishment of dietary guidelines. Still other agencies oversaw the creation of a children's food industry, the formulation of laws protecting children's health, and the establishment of agencies to enforce them (Guldan 2000; Zhao Yang 2000).

In the 1990s in China, as in the West, the explosion of the market brought a growing commercialization of childhood and new definitions of child quality in terms of the consumption of goods and services. Foreign firms played an active role in this process. Since the early 1990s when corporations were permitted to advertise their products on television, prominent transnational firms such as McDonalds, Kentucky Fried Chicken, and Heinz became some of the biggest promoters—and sellers—of "child quality". These companies have defined the public's needs in terms of the consumption of their products. McDonalds has been especially creative and successful in tapping into parental anxieties, advertising its food as scientifically designed and nutritionally beneficial. Parents have responded enthusiastically, seeing opportunities to nurture the bodies and minds of their youngsters while giving them an opportunity to participate in transnational, especially US, culture at the same time. Food and pharmaceutical companies have introduced an ever-proliferating number of infant, baby, and toddler products, all colorfully packaged and offered at much higher cost than Chinese goods, associating their goods with science, modernity, foreignness and progress. By the turn of the century, the politics of population quality had been deeply infused with the market logics of individual consumer desire and global consumption fantasy—the fantasy that one can participate in global culture and even become a kind of global person through the consumption of foreign, especially Western products.

To produce this "quality" child, parents have made enormous sacrifices, spending over half their monthly incomes on their youngsters. These

extraordinary efforts have been driven by deep parental desires, anxieties, and fears (Anagnost 1997; Fong 2004; Lei 2003; Rosen 2004). The desire is to compensate for their own deprived Cultural Revolution childhoods by ensuring that their child has everything they did not. The anxiety is of losing their privileged position in an economy increasingly marked by growing economic differentiation. The fear is that their only child might eventually abandon them—financially, socially, and/or emotionally. To counter that dreaded prospect, parents have "drowned their children in love" (*ni ai*) and commodities in the desperate hope that those investments will be reciprocated by filial comfort, economic support, and nursing care in old age.

Parental overindulgence has led to the emergence of the quintessential self-cultivating and self-regulating neo-liberal subject: the child itself. Anxious to secure their child's affections, parents have allowed their youngsters to make decisions on everything from food to entertainment to large commodity purchases, including numerous items that affect their health, education, and training (Chee 2000; Guo 2000; Iritani 2003; Lozada 2000; Watson 1997; Yan 1997). China's little emperors and empresses have become the "single greatest force in determining consumer decisions today" (Tyler 1996: A6). In a process that the regime probably did not envision, certainly does not control, yet may ambivalently endorse, market forces have combined with the state's programmatic efforts and societal dynamics to create a new kind of highly independent, market-minded "quality" person who will increasingly make up the citizenry of 21st century China. The result is a kind of "autonomous" neo-liberal subject whose interests, desires, and choices align with those of a neo-liberalizing market and state that have shaped those interests, desires, and choices to their own ends.

Since the birth of its first members around 1980, this new generation of singletons has been the beneficiary of unprecedented state and familial largesse, which, combined with a booming commodity culture, has produced the most materially and educationally privileged generation of young people in Chinese history. Identified as the hope of the nation's global future, these youngsters have been catapulted into that brave new world with global commodities, global technologies, global experiences and more. Their lives endlessly celebrated and obsessively charted, China's first generation of singletons is one of the best-known outcomes of the

one-child policy, not only in China but around the world, which partici-
pates in the fascination with this exotic new creature: the cosmopolitan
Chinese.

Less well known outside China are the improvements the birth program
has helped to bring about in the well-being and opportunities of (surviving)
daughters. In both urban and rural areas, the sharp drop in the number of
children has combined with changes in family structure and sentiment
to produce a dramatic reevaluation by parents of the worth of sons and
daughters. In the cities, girls have been considered as good as boys. In
the villages, girls who survived the treacherous waters of fetalhood and
infancy could expect not only better care than in the past, but also a rise
in status relative to their brothers.

Certainly, the experts and the public at large are right to worry about
the psychological and social problems attending the creation of these
little emperors and empresses (Fong 2004: 127–77). Due to the focus of
intense societal and familial attention, today's single children face pres-
sures to succeed that are almost too great to meet and owe a debt of love
to their parents that is almost too vast to repay (Iritani 2003; Jing 2000a).
Overwhelmed by the strict discipline and demands, in some rare cases
children have ended their own lives, suggesting the extremes to which
parent–child relations have been strained. With parental anxieties,
corporate interests, professional, and state concerns all converging on the
single child, few periods and few arenas of a young child's life are left
unprogrammed. Chinese children growing up over the 1980s, 1990s, and
early 2000s have lived closely monitored, managed, disciplined, and even
regimented lives (Tyler 1996). The larger society, too, must pay a price for
what it has created. Chinese society must now find a place for what by
most accounts is a materialistic, consumeristic, narcissistic generation of
young people whose material riches seem matched by their incivility and
moral poverty (Rosen 2004; Yan 2003).

China's society and government must also find a place for the many
publicly invisible, "unplanned" children, mostly girls, who represent the
dark underside of the planned birth program. Usually as the second- or
third-born offspring, these children were born outside the birth planning
regime and so are not supposed to exist. Deprived of state support and
located outside the community of legitimate citizens, these children have
endured multiple forms of discrimination, becoming the "low quality"

young people the birth program has tried so hard to eliminate. Individual stories from the press suggest that unplanned children tend to feel unwanted from an early age, unimportant compared to their siblings, and a burden to their parents, who have often had to endure nightmarish bureaucratic travails in their efforts to obtain registration for such children (Greenhalgh 2003; Johnson 2004). The legal exclusion of unplanned children from schools and other mainstream institutions only deepens their sense of deprivation. Although some, perhaps even many, parents have managed eventually to purchase or otherwise arrange for registration for their unauthorized child, many illegitimate children have remained outside the registration system for years, becoming not just unplanned children but also unplanned adolescents and even young adults, statuses fraught with difficulties. The state has not counted the numbers of its unplanned citizens, but it is estimated that as of 2000, as much as 11 percent of China's population (135 million born between 1979 and 1999) may have come into the world unplanned. Even if only a small proportion of that estimated 100 million-plus population of unplanned infants failed to obtain official registration, the absolute numbers of illegitimate young persons would be very large.

CONCLUSION: NEW DIRECTIONS IN CHINA'S POPULATION POLICY

The greatest social engineering venture of the reform era, the state's birth planning project, sought to trim and upgrade the Chinese population in order to speed China's transformation into a global power. The post-Mao birth project helped to create a hard-edged, competitive Chinese modernity in which the new generation of "quality", cosmopolitan, and consumerist singletons exists in a larger cultural sea of peasant suffering and female sacrifice. Despite the PRC's constitutional commitment to the equality of men and women, in the 1980s and 1990s the birth planning establishment, with the support of the political leadership, in effect used actually existing gender inequality for its own purposes, reducing population rates on the backs of reproductive women and infant girls, born and unborn. More charitably, it deemed the damage to women and girls the "unfortunate costs" of achieving a "higher goal". However they are represented, the unintended

result was a perpetuation of the idea of girls' lesser value, the widespread loss of fetal life, and extremely distorted sex ratios that constitute, in the words of one prominent Chinese demographer, "the crime of the twentieth century against the twenty-first" (Interview conducted by the author on November 28, 2001 in the USA).

Since the mid-1990s, China's leaders have become increasingly concerned about the "heavy side costs" of the birth program, including the harm done to the vital interests of women. In response to a range of forces—including rapidly falling fertility levels, due in part to the birth program and in part to rapid development, domestic political changes, and China's growing integration into global social policy networks—China's population policymakers have responded to the UN's 1994 Cairo International Conference on Population and Development initiative in international population policy in important ways. Not only has policy enforcement become more woman-centered, but in addition the government has taken major steps to discourage the practice of sex-selective abortion, and to arrest the rise in the sex ratio at birth. In addition to the regulation of ultrasound devices, policymakers have introduced major initiatives to improve women's status, ensure old-age security, and connect birth planning with poverty alleviation. In 2000, they set the normalization of the sex ratio as a goal for 2010. Since then, with new political leaders in charge and new awareness that the culprit is not only the birth program but also the larger culture, the government's commitment to addressing the problem has intensified. In January 2003, Premier Hu Jintao told the birth planning establishment that it must arrest the rise in the sex ratio. To this end, the population and birth commission launched an important new program, the Action to Foster Girls (*guan'ai nuhai xingdong*), in counties with extremely high sex ratios at birth. In March 2004, the Ministry of Finance announced a major new pension program for couples with daughters that represented a "huge commitment of political will" (Interview conducted by the author on December 22, 2003 in Beijing; *China Daily* 2004). In early 2005, population and birth minister Zhang Weiqing announced the government's intention to amend the criminal law to outlaw fetal sex-identification and sex-selective abortion, allowing those practices only for legitimate medical purposes (*China Daily* 2005).

These initiatives, coupled with transformations in the birth program aimed at shifting to more indirect techniques of control and transferring

more responsibilities for reproductive management to Chinese citizens—
reflected in the "Comprehensive Reform" of the 21st century—are
extremely encouraging developments. Yet the challenges ahead are
daunting. Short of immediate society-wide improvement in women's
status—a goal difficult to achieve given the masculinizing trends in the
larger reform environment—arresting the practice of sex-selective abor-
tion and the rise in the sex ratio at birth might well require vigorous public
condemnation by top PRC leaders, coupled with relaxation of the tight
restrictions on childbearing. Perhaps now that the one-child policy has
served its demographic purpose (the average number of children women
give birth to is 1.55) and the costs are visible for all to see—indeed, top
leaders Hu Jintao and Wen Jiabo are now openly trying to alleviate these
and other social problems—the time might be ripe for a policy change.
Some social demographers have proposed a smooth, phased transition to
a universal two-child policy with late childbearing by around 2013–2015,
followed by the elimination of all restraints on reproduction by around
2030–2035 (Zeng 2007). Comparison of various policy options in terms
of social and economic costs (in population ageing, elderly living arrange-
ments, pension deficits, labor force supply, the marriage squeeze, and so
forth) leaves little doubt that the interests of the country, of families, and
of women and girls would be best served by starting the transition to such
a policy as soon as possible. A shift to a two-child policy would not solve
the sex and age-structure problems, but it would help slow the growing
social crises of masculinization and ageing-without-social security and
alleviate a host of other serious problems. A policy change would have
political benefits as well. It would ease the conflicts over birth policy,
which persist today in some poorer localities. It would support leaders'
claims that the party cares for rural people. And it would bring China's pol-
icy more in line with international thinking, which holds that population
policies should protect women's lives and that the number of children a
couple has should be freely chosen.

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NOTES

1. The trauma of village cadres charged with enforcing a widely hated policy among their relatives and neighbors was expressed in nightmares, resignations and even, in rare cases, attempted suicides (Mueggler 2001). Many quietly refused to enforce the policy or effectively obstructed enforcement by such means as breaching the rules themselves or falsifying the numbers they reported to superiors (see Scharping 2003: 198, data from 1988 and 1995).
2. While daughter desire is growing in some areas, in parts of south and central China (such as Anhui, Guangdong, Guizhou, and Jiangxi), son preference remains intense (Feng and Zheng 2002; Ku 2003; Interviews conducted by the author on December 11–12, 2003 in Beijing).
3. Beginning in the early 1990s, the policy was enforced by tight administrative means—frequent gynecological exams for women, steep fines for couples, mandatory sterilization for those with two children, tough responsibility systems for cadres—that left local society few options but to comply.
4. The untimely death of infant girls has also been tied to discrimination in the distribution of medical care in the family. In parts of rural Shaanxi in the mid-1990s, more than one quarter of deaths among young girls were beyond expected levels—and the percentage was rising (Li et al. 2004).
5. During the 1990s, the majority of urban women came to view one child as the ideal number, but in the early 2000s childbearing norms seem to have fallen even further. Young couples wanting no children were a growing social presence, exceeding 10 percent of all reproductive-age couples in major cities (*China Today* 2003). Most urbanites expressed no preference regarding the gender of their child. Indeed, in some studies, more respondents preferred daughters than sons (Feng and Zheng 2002). Nonetheless, sex ratios, while lower than those in the countryside, are also a highly skewed 113 in China's cities. In 1999 the globalizing cities of Guangdong had a sex ratio of 128, the national capital Beijing 133, and the cosmopolitan Shanghai 111. Within the urban population, the children of the most advanced segments of society—younger, better educated, nonmigrant women in cadre and technical jobs—had some of the highest sex ratios at birth (Chen 2003).

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This book is a must read for all those who are concerned about the lives of poor women. This remarkable collection of essays shows us, through case studies from across the world, how the Cairo Conference's call for reproductive rights have been subverted by neo-liberal economic policies to promote fertility control at the cost of women's health.

Brinda Karat
Member of Parliament (India) and women's rights activist

In the current climate when overpopulation arguments are again prominent, this book is essential reading for health and women's rights activists and indeed policy-makers. It explores how the promises of reproductive health and rights at the ICPD in Cairo in 1994 were hollowed out by neo-liberalism. Both market fundamentalism and religious fundamentalism took their toll.

Shabana Azmi
Actor, former member, Population Commission, and women's rights activist

Markets and Malthus: Population, Gender, and Health in Neo-liberal Times explores the ideas and institutions that were framed at the 1994 United Nations population conference in Cairo and traces their trajectories sixteen years down the line. Why were Third World feminists profoundly critical of the Cairo consensus and process? How has the health of people around the world been affected by neo-liberal economic policies? What have these meant for women's rights, including reproductive rights?

The book presents detailed case studies from various countries ranging from India and China to Egypt, Tanzania, Uganda, and across Africa to Argentina, Peru, and throughout Latin America, as well as overarching themed essays. From the politics of abortion and immigration to rising levels of fundamentalist violence and sex selective abortions, the volume explores a range of issues from several vantage points. It offers startling new insights into these issues by linking them to neo-liberal economic policies that have profoundly shaped health policies globally. This book is essential reading for students of gender studies, public health, and demography, as well as policy-makers and activists.

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